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ABSTRACT

In 1991, a study was conducted to evaluate intake assessment at the various adolescent alcohol and drug treatment centers in Washington State. The three goals of this study were: (1) investigate the level of agreement among drug treatment professionals on the placement of adolescents in different treatment programs; (2) evaluate the existing placement process; (3) identify the most important factors influencing primary treatment placement decisions. Seventy-two assessment files were gathered from various types of treatment facilities. Six major findings emerged: (1) the number of cases for which consensus was attained was higher in the Team Review than in the Independent Review, for both realistic and ideal placements; (2) in both the Independent and Team review, there was a very high level of correspondence between the realistic and ideal placements; (3) in the majority (68%) of cases in the Independent Review, the recommended primary treatment duration was the same for realistic and ideal placement; (4) there was a low level of agreement between the panelists' recommended placements and the actual treatment the clients received; (5) drug history factors were identified as paramount in making placement decision; and (6) little standardization of the adolescent assessment process exists. (KM)

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ED 374 359

REPORT

TREATMENT PLACEMENT DECISIONS FOR ADOLESCENT CLIENTS OF WASHINGTON STATE'S DIVISION OF ALCOHOL AND SUBSTANCE ABUSE

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TREATMENT PLACEMENT DECISIONS FOR ADOLESCENT CLIENTS OF WASHINGTON STATE'S DIVISION OF ALCOHOL AND SUBSTANCE ABUSE

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Planning, Research, and Development
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EXECUTIVE SUMMARY

In the fall of 1991 a study was undertaken on the current intake assessment processes used at Washington state's adolescent alcohol and drug treatment centers, by the Adolescent Project in the Office of Research and Data Analysis. There were three main objectives for this study:

1) To investigate the level of agreement among drug treatment professionals on the placement of adolescents in different treatment programs.

2) To evaluate the existing placement process.

3) To identify the most important factors influencing primary treatment placements decisions.

METHODOLOGY

Fifteen alcohol and drug treatment specialists from around the state were selected to participate in this Peer Panel Review.

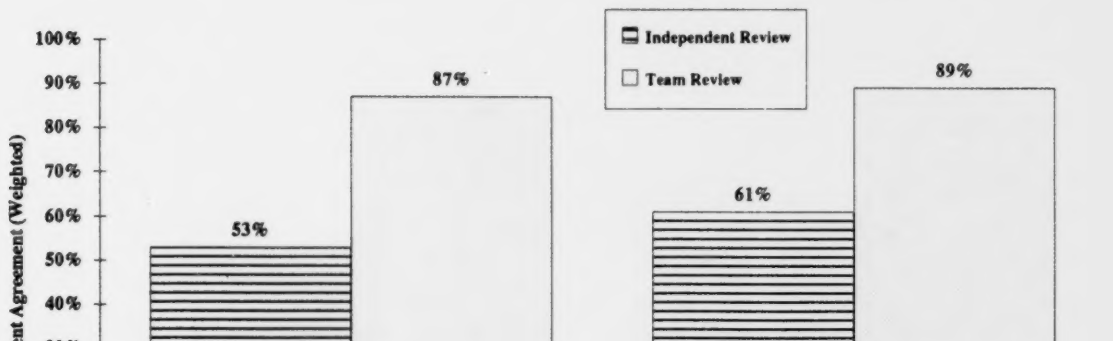
Seventy-two client assessment files were selected from 110 files gathered around the state. Forty-eight assessments came from Regular Outpatient facilities, twelve from Intensive Outpatient facilities, and the remaining twelve from Inpatient facilities.

The assessments were first reviewed independently by the panelists (Independent Review), and then in teams of three (Team Review). For each case, the panelists determined primary treatment placement choosing one of three modalities: Inpatient, Intensive Outpatient, and Regular Outpatient. They did this for both ideal conditions (that is, given all conceivable resources) and realistic conditions (just those resources available in the panelist's region.) Additionally, they determined appropriate duration of primary treatment and, from a predetermined list of 41 factors, they selected the five most critical in making their placement decisions.

MAJOR FINDINGS AND IMPLICATIONS

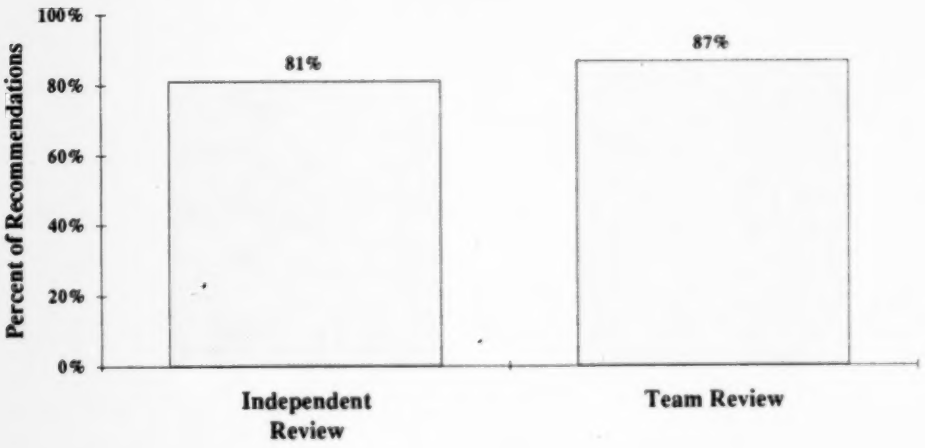
1. The number of cases for which consensus was attained was higher in the Team Review than the Independent Review, for both realistic and ideal placements. In the Independent Review, agreement (weighted) was reached, within a team of three, for realistic placements in 53% of the cases and for ideal placements in 61% of the cases. (Agreement was defined as all three team members agreeing on placement.) The level of agreement increased significantly in the Team Review: 87% for realistic placements and 89% for ideal placements (Graph 1). This increase in consensus may be a result of the informative nature of the discussions in which key aspects of the assessments were highlighted. It may also be a result of group dynamics, with individuals gravitating toward majority opinions.

GRAPH 1: PERCENT CONSENSUS AMONG PANELISTS IN PLACEMENT



2. In both the Independent and Team reviews, there was a very high level of correspondence between the realistic and ideal placements (Graph 2). The high level of correspondence between the proposed ideal and realistic placements indicates that the panelists are satisfied that the treatment modalities they see as needed for adolescent clients exist in their communities.

GRAPH 2: PERCENT CORRESPONDENCE BETWEEN REALISTIC AND IDEAL PLACEMENTS



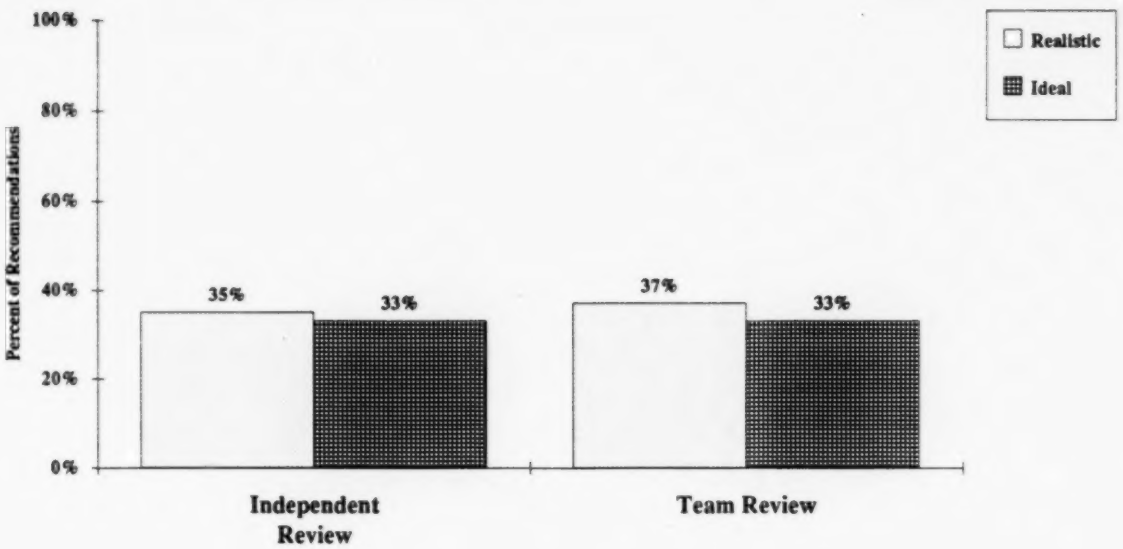
3. In the majority (68%) of cases in the Independent Review the recommended primary treatment duration was the same for realistic and ideal placements. However, the mean recommended durations (Table 1) show an increase from realistic to ideal for all three treatment modalities: about one month more for Inpatient and Intensive Outpatient. This increase was statistically significant (p=0.05) for recommended Inpatient and Intensive Outpatient durations, and suggests a need to increase available treatment length for these two modalities.

TABLE 1: MEAN DURATION OF PRIMARY TREATMENT WHEN TREATMENT WAS THE SAME FOR REALISTIC AND IDEAL PLACEMENTS, INDEPENDENT REVIEW

TREATMENT MODALITY	REALISTIC PLACEMENT	IDEAL PLACEMENT	PERCENT INCREASE
Inpatient (N=140)	2.0 months	3.2 months	65%
Intensive Outpatient (N=48)	5.6 months	6.6 months	18%
Regular Outpatient (N=49)	5.2 months	5.6 months	7%

4. There was a low level of agreement between the panelists' recommended placements and the actual treatment the clients' received. In the Independent and Team Reviews, the panelists' realistic and ideal recommendations were compared to the actual treatment the clients received. In all four reviews, 33-37% of the cases actually received the treatment for which they were recommended. The majority of cases were recommended for treatment that differed from what they actually received.

GRAPH 3: PERCENT OF PANELISTS' PLACEMENT RECOMMENDATIONS THAT CORRESPOND WITH ACTUAL TREATMENT RECEIVED



5. Drug History factors were identified as the most important ones in making placement decisions. The panelists rank ordered the five most important factors in making their placement decisions. These factors were grouped into seven categories: Drug History, Family History, Medical Concerns, Social Background, Personal Development, High Risk Behaviors, and Other. Drug History factors were selected most frequently for the Independent and Team Reviews, for both ideal and realistic placements. In both reviews, Personal Development and Medical Concerns were identified least often. In 79% of the cases, the panelists cited the same factors for realistic and ideal placements. Table 2 presents the distribution of factors selected by the panelists for the independent ideal review.
(15 panelists x 24 cases x 5 factors = 1800 total factors selected).

TABLE 2: DISTRIBUTION OF FACTORS, BY CATEGORY, FOR INDEPENDENT IDEAL REVIEW

Category	Independent Review	
	Realistic Placement (N=1800)	Ideal Placement (N=1800)
Drug History	37%	34%
Family History	17%	18%
High Risk Behavior	14%	13%
Social Background	11%	10%
Personal Development	3%	2%
Medical Concerns	2%	3%
Other	7%	8%
No Response	10%	13%
TOTAL	**100%**	**100%**

6. Presently there is little standardization of the adolescent assessment process. In an evaluation completed after the meeting, 88% of the panelists stated more seminars and training geared toward standardizing assessments and intakes would be helpful. Likewise, an agreement level of 53% (Graph 1) further supports the need for greater standardization.

CHAPTER I: INTRODUCTION

Treatment of adolescents for chemical dependencies is a relatively new field. Little information is currently available on the methods and trends of assessment practices in this field (Winters, 1990). A survey of over 70 adolescent chemical dependency facilities found considerable variation in assessment processes, and a heavy reliance on clinical judgement (Owen and Nyberg, 1983).

As the adolescent treatment field grows, there may be greater diversity among professionals which could lead to greater variability in placement decisions. Additionally, expansion of the field may increase the variety of treatment options available. This, as well, could lead to greater variability in placement decisions.

This study was undertaken to examine the assessment process in Washington state's adolescent alcohol and drug treatment programs. The following questions were addressed.

1) Do professionals agree on the appropriate choice of treatment for adolescents?

2) Does the presence of results from standardized assessment tools (such as the Personal Experience Inventory) affect this level of agreement?

3) If a treatment specialist could place a client in an ideal treatment facility, would this differ from their realistic placement?

4) What is the level of professional agreement on the length of primary treatment?

5) What factors are involved in making a treatment placement decision?

6) How well is the current system placing adolescents into treatment programs?

To answer these questions, a panel of 15 Washington state treatment specialists was established. The panelists, independently and in teams, reviewed 72 assessment files from treatment facilities around the state. For each case, the panelists recommended a treatment placement choosing one of three modalities: Inpatient, Intensive Outpatient, and Regular Outpatient. They also recommended the duration of treatment, and selected the five most important factors influencing their placement decision.

CHAPTER II: STUDY DESIGN

A: METHODOLOGY

Fifteen alcohol and drug treatment specialists from around Washington State were selected to participate in the Peer Panel Review. The 15 panelists were divided into five teams of three, to review cases and recommend treatment placements.

The assessments of 72 cases were selected from around the state for the panel review. Twelve of these cases were "common cases", i.e. reviewed by all 15 panelists. The remaining 60 were "team-specific" cases, i.e. each case was reviewed by only one 3-person team. The cases were actual DASA-funded (Division of Alcohol and Substance Abuse) clients, though the panelists were not told what type of treatment the clients received.

Each panelist independently reviewed 24 cases. Members of the same team reviewed the same set of 24 cases. Following their Independent Reviews, the panelists met with their teams for two days to discuss the cases (Team Reviews).

In both the Independent and Team Reviews, panelists were asked to determine appropriate primary treatment placement under both realistic and ideal conditions. Panelists were instructed to define realistic conditions as the current circumstances present in their own region. Thus, each panelist had a different framework with which they approached their realistic placement decisions. Ideal conditions were defined as having all resources readily available, no financial constraints, and space available in all programs. The panelists also decided appropriate primary treatment duration.

Prior to the Independent Review and Peer Panel Review, a procedural meeting was held with the panelists. At this meeting the panelists generated a list of 74 factors that influence treatment decisions. They divided these factors into seven categories: Drug History, Family History, High Risk Behaviors, Social Background, Personal Development, Medical Concerns, and Other (miscellaneous). Following this meeting, the panelists were sent the list of 74 factors, and asked to identify the 35 factors most critical in making placement decisions. The results were tallied, and the top 41 were included in the Independent Assessment form completed by the panelists for each case. The 41 factors were distributed across the seven categories as follows.

TABLE 2-1: NUMBER OF FACTORS IN EACH CATEGORY

CATEGORY	NUMBER OF FACTORS
Drug History	11
Family History	6
High Risk Behaviors	5
Social Background	6
Personal Development	5
Medical Concerns	5
Other	3

See Appendix A for a complete list of the factors.

B: SELECTION OF ASSESSMENT CASES

One hundred and ten assessment cases were gathered from 23 treatment facilities around the state. (See Appendix B for a list of the treatment facilities.) All assessments had been conducted in 1991, and all cases were at least partially funded by the Division of Alcohol and Substance Abuse. Seventy-two cases were selected from the 110 that were collected. An informal selection process took several factors into account. These factors were:

1. Regional/Statewide Selection,
2. Socio-Demographic Characteristics,
3. Treatment Modalities; and
4. Drug History and Use Patterns.

1. Regional/Statewide Selection:

The cases selected were from the six different regions in Washington. Table 2-2 presents the number of cases reviewed from each region, the percent of the total sample reviewed from each region, and the percent of actual adolescent DASA clients from each region. (Clients from three western Washington regions were over-represented in the sample as compared with actual DASA clients.)

TABLE 2-2: REGIONAL DISTRIBUTION OF CASES

Region of WA State	Distribution of Actual DASA clients *	Number of Cases	Percent of Total Sample
I	12%	3	4%
II	20%	6	8%
III	7%	1	2%
IV	28%	29	40%
V	17%	15	21%
VI	16%	18	25%
Total	100%	72	100%

* Estimates from Client Descriptive Study, Adolescent Project, Office of Research and Data Analysis, DSHS.

2. Sociodemographic Characteristics:

In the sample cases, there were 47 male clients and 25 female clients. 41% of DASA clients are female.* Table 2-3 presents the age distribution of actual DASA clients, and the number and percent of cases reviewed by the panelists, by the clients' ages.

TABLE 2-3: AGE DISTRIBUTION OF CASES

Clients' Ages	Distribution of Actual DASA clients *	Number of Cases	Percent
< 13	9%	4	5%
14-15	34%	25	35%
16-17	45%	38	53%
18	8%	5	7%
Total	96%	72	100%

* Estimates from Client Descriptive Study, Adolescent Project, Office of Research and Data Analysis, DSHS. Total does not add to 100%, because of 4% unknown.

3. Treatment Modalities:

Proportional numbers of cases of adolescent clients were selected from the different treatment modalities relative to those which currently exist for DASA adolescent clients in treatment around the state. In DASA facilities, statewide, client distribution by modality is of the order: 67% Regular Outpatient, 14% Intensive Outpatient, and 19% Inpatient.

TABLE 2-4: TREATMENT MODALITY DISTRIBUTION OF CASES

Treatment Modality	Client Distribution Within DASA Facilities (1990) *	Cases Reviewed by Entire Panel % (N)	Cases Reviewed by Each Panelist % (N)
Inpatient	19%	17% (12)	17% (4)
Intensive Outpatient	14%	17% (12)	17% (4)
Regular Outpatient	67%	67% (48)	67% (16)
Total	100%	100% (72)	100% (24)

* Estimates from Client Descriptive Study, Adolescent Project, Office of Research and Data Analysis, DSHS.

4. Drug History and Use Patterns:

Different client drug history and use patterns were selected. In choosing the 72 cases, an informal and unsystematic attempt was made to include cases ranging in severity from experimental use to addiction. Consideration was given to the type of drugs used, length of use, amount used, and pattern of use.

Once the 72 cases were selected, all client identifying information was deleted from each client's assessment form. This included: name of client, family and friends, address(es), schools attended, and name of facility from which the case was selected. In addition, treatment recommendations, counselors' impressions, and diagnoses were deleted. This was done to ensure that only objective, factual information was provided to the panelists. Thirty-one of the cases included summaries from the Personal Experience Inventory (PEI). The 72 cases were distributed in such a way that no panelist evaluated his or her own facility's assessment forms.

C: SELECTION OF PANELISTS

The six DASA Regional Administrators provided suggestions for possible panelists from each of their regions. They were asked to consider length and breadth of experience, and professional reputation, in making their suggestions. The desire was to include professionals with counseling and intake assessment experience. Many of the professionals have administrative experience as well. The six Regional Administrators provided a total of 33 names.

One assumption of the Peer Panel Review is that the fifteen panelists are representative of the professionals working in the adolescent treatment field. To best achieve this, several factors were considered in selecting the final fifteen candidates from the regional administrators' 33 suggestions.

1. **Representation of the Different Adolescent Treatment Modalities: Inpatient, Intensive Outpatient, and Regular Outpatient:** Of the fifteen panelists, five worked in Inpatient facilities, four in Intensive Outpatient, and three in Regular Outpatient. One worked in a school setting, one in the prevention division of a County Health Department, and one in a MICA (Mentally Ill and Chemically Addicted) program.

2. **The Variety of Employment Positions for Treatment Professionals:** Five of the panelists worked primarily as treatment counselors, eight were treatment program administrators (treatment and program directors, and admissions coordinators), one was a school counselor, and one worked as an administrator in a County Health Department.

3. **Experience Working in More Than One Treatment Facility and Modality:** 87% had experience working in more than one treatment facility and modality.

4. **A State-Wide Regional Distribution:** The panelists represent all six state regions, and come from nine different counties, including four from eastern Washington.

5. **A Balanced Number of Men and Women:** There were eight women and seven men on the panel.

6. **Representation of Different Ethnic and Minority Populations:** Two of the panelists were African-Americans, and one was Native American. The rest were Caucasian.

The five teams of three were composed in a way to most equally distribute the panelists by gender, region, and the treatment modality in which they work.

D: MODERATORS AND OBSERVERS

A moderator was assigned to each team of three peer panelists. The role of the moderator was to facilitate the discussions and record the treatment placement decisions. Moreover, the moderators were responsible for ensuring that all panelists had an opportunity to speak, and that the time was closely monitored so all cases would be reviewed within the allotted time. The moderators were instructed to remain impartial and objective in their approach. Four of the moderators are professionals in the field, and the fifth is a Research Analyst with the Adolescent Project in the Office of Research and Data Analysis, DSHS.

In addition to the moderators, each team also had an observer. The observers were responsible for objectively recording the nature of the discussions. Because objectivity was crucial to their role as an observer, none of the them was working or involved in the field of substance abuse. They were graduate students and college staff selected from the University of Washington, Seattle and The Evergreen State College, Olympia. They received a half-day training session in which observational techniques were taught and practiced. They also participated in a half-day debriefing session after the Peer Review in which they shared their observations about the content and nature of the discussions. In addition, they wrote extensive notes describing the discussions that ensued.

SIGNIFICANCE

All tests in the report were run at $p=0.05$ using t-tests or X^2 tests. See Appendix E for the list of tests run for each comparison.

CHAPTER III: STUDY FINDINGS

A: MAJOR FINDINGS

- Consensus (weighted) increased significantly from the Independent Review to the Team Review, for both realistic and ideal placements. For realistic placements, consensus (weighted) increased from 53% to 87%; for ideal placements, it increased from 61% to 89 percent.

- In 81% of the Independent Review cases, panelists recommended the same treatment under ideal and realistic conditions. For the Team Review, 87% of the cases were recommended for the same treatment under both conditions.

- The recommended duration of treatment increased significantly from realistic to ideal placements for Inpatient and Intensive Outpatient. For Regular Outpatient, recommended duration remained the same.

- The majority of clients (77%) recommended by the panelists for Regular Outpatient treatment were actually placed in this modality. However, few of the clients (26%) recommended for Inpatient treatment actually received Inpatient treatment, and even fewer (17%) of the clients recommended for Intensive Outpatient treatment received this treatment.

- Drug History factors were identified as most important in making placement decisions, followed by Family History factors and High Risk Behavior factors.

B: LEVEL OF AGREEMENT AMONG PANELISTS

Each panelist reviewed 24 cases, first independently and then in teams of three. In both the Independent and the Team Review, the panelists determined treatment placement under both ideal and realistic conditions. Recommendations were evaluated for level of agreement within each team as follows:

1. Complete Agreement or Consensus: all three team members recommended the same treatment modality for a given case.

2. Majority Agreement: two of the three team members recommended the same modality, and the third differed in his or her recommendation.

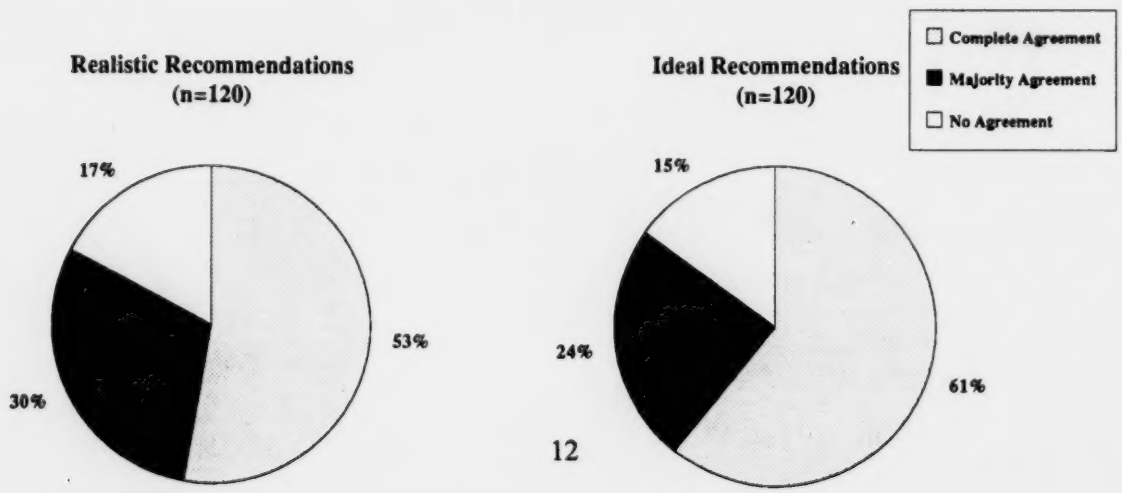
3. No Agreement: all three panelists recommended different treatment modalities.

Weighted values were used to account for the probability of obtaining complete agreement, majority agreement, and no agreement. The weighting procedure was used because the probability of reaching complete agreement among three panelists in a team is much less than reaching majority or no agreement. (See Appendix C for a description of the weights and a report of the raw numbers.)

Agreement in the Independent Review

When determining realistic placements, complete agreement was reached in 53% of the weighted cases in the Independent Review. For ideal placements, complete agreement was reached in 61% of the weighted cases. Panelists reached majority agreement less frequently for both realistic and ideal placements, 30% and 24% respectively (Graph 3-1).

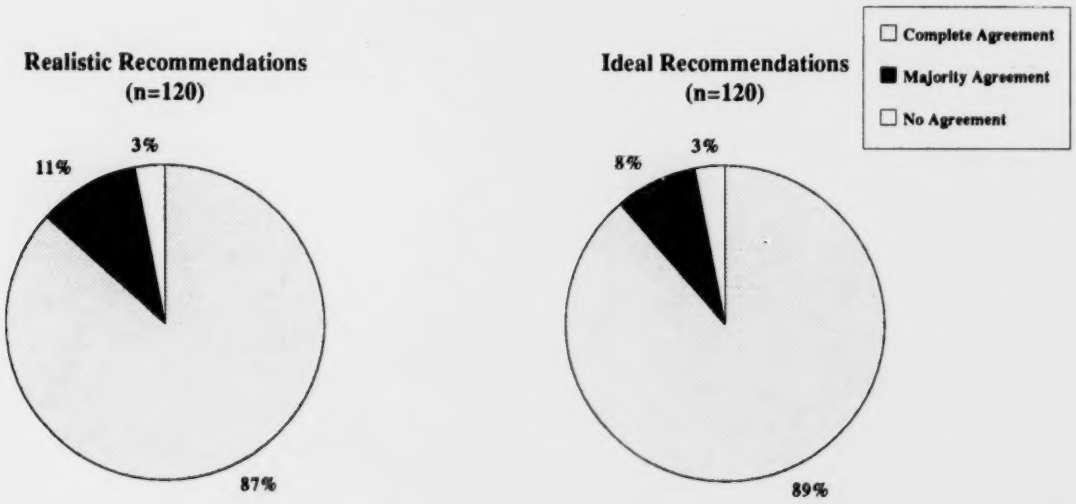
GRAPH 3-1: DEGREE OF CONSENSUS AMONG PANELISTS IN THE INDEPENDENT REVIEW (WEIGHTED CASES)



Agreement in the Team Review

In the Team Review, the panelists reached consensus in 87% of the weighted realistic placements, and 89% of the weighted ideal placements. They reached majority agreement less frequently: 11% of the weighted realistic placements, and 8% of the weighted ideal placements (Graph 3-2).

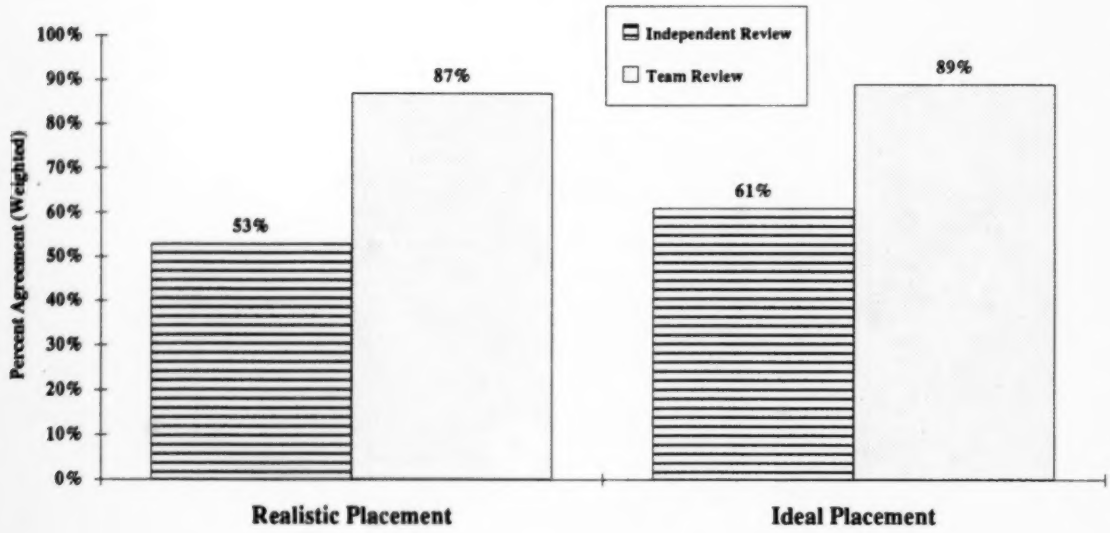
GRAPH 3-2: DEGREE OF CONSENSUS AMONG PANELISTS IN THE TEAM REVIEW (WEIGHTED CASES)



Comparison of Agreement in the Independent and Team Reviews

Complete agreement (weighted) increased significantly from the Independent Review to the Team Review. Complete agreement increased for both realistic and ideal placements, from 53% to 87%, and 61% to 89% respectively (Graph 3-3). After meeting and discussing the cases, the panelists, within their teams of three, more frequently recommended the same treatment.

GRAPH 3-3: COMPARISON OF RATES OF COMPLETE AGREEMENT FOR PLACEMENTS, AMONG PANELISTS IN INDEPENDENT AND TEAM REVIEWS



Note: Because these bars show only complete agreement, they do not add to 100 percent.

In the group meeting held after the Team Review, the panelists provided possible explanations for these findings. They suggested that the increase in agreement was due largely to the informative nature of the discussions. By presenting and discussing their ideas, the panelists felt they were able to gain a more comprehensive and thorough understanding of the individual cases. However, when the team recommendations for individual cases are examined, another explanation is suggested. In cases that were reviewed by all teams (common cases) intra-group agreement was often reached (consensus within the groups of three), while inter-group agreement (between the five teams of three) was not often reached. This suggests that group dynamics (the tendency of an individual to agree with the majority) may have played a larger role in the level of consensus than did a new understanding of the case.

In addition to the disparity across teams in their recommendations for a particular case, the overall distribution of individuals' recommendations further suggests that group dynamics played an important role in the Team Reviews. Although there was a significant increase in the level of consensus after the Team Review, the distribution of placements across the three modalities changed very little. Table 3-1 presents the percent of cases placed in each treatment modality. There was no statistically significant difference between the Independent and Team distributions of recommendations. For example, the percentage of ideal recommendations for Inpatient did not increase significantly from Independent (48%) to Team (54%).

TABLE 3-1: PERCENT OF CASES PLACED IN EACH MODALITY

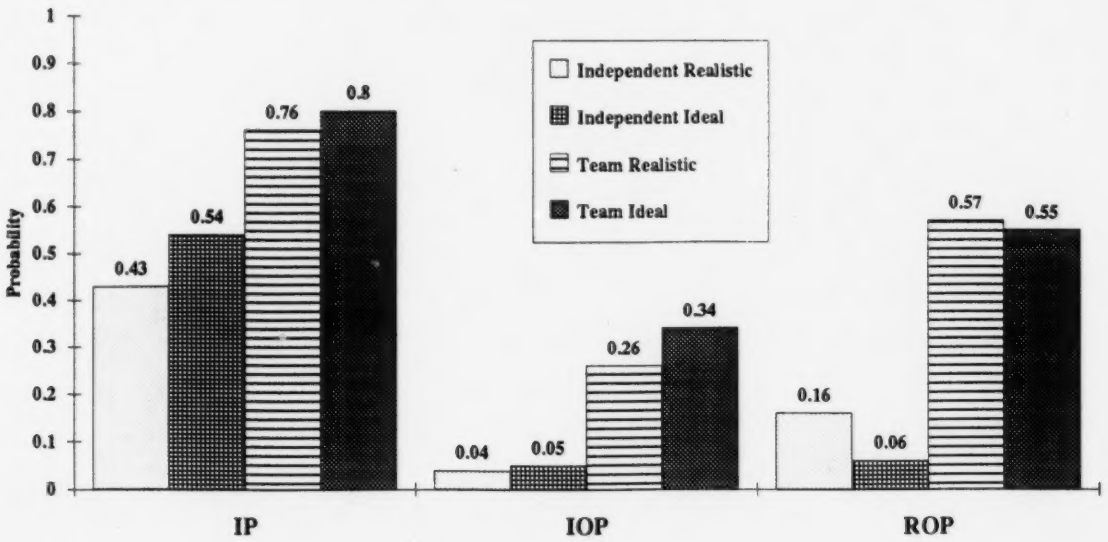
TREATMENT MODALITY	INDEPENDENT REVIEW		TEAM REVIEW	
	REALISTIC	IDEAL	REALISTIC	IDEAL
Inpatient	40%	48%	46%	54%
Intensive Outpatient	21%	18%	19%	12%
Regular Outpatient	21%	14%	19%	17%
Other	18%	20%	16%	17%
Total	100%	100%	100%	100%

Probability of Three Panelists Agreeing

To further explore the level of agreement, the panelists' recommendations were studied by modality. When a panelist recommended a treatment modality, the probability of the other two panelists on the team agreeing with that recommendation was analyzed by the recommended modality (Graph 3-4).

Of the three possible recommended modalities, the probability of reaching agreement among three panelists for Inpatient placement recommendations was consistently the highest. That is, when a panelist recommends Inpatient in the Independent Realistic evaluation, there is a 0.43 probability that the other two panelists will agree; whereas, if a panelist recommends Intensive Outpatient or Regular Outpatient for realistic placement, there is only a 0.04 and 0.16 probability respectively that the other two panelists will also recommend those modalities. While the probability of reaching complete agreement increases for all three modalities from Independent to Team Reviews, when Intensive Outpatient is recommended, the probability of two other panelists agreeing with that modality is consistently lower than for Inpatient and Regular Outpatient. This difficulty in reaching complete agreement suggests that there may be some ambiguity in the definition of Intensive Outpatient treatment programs.

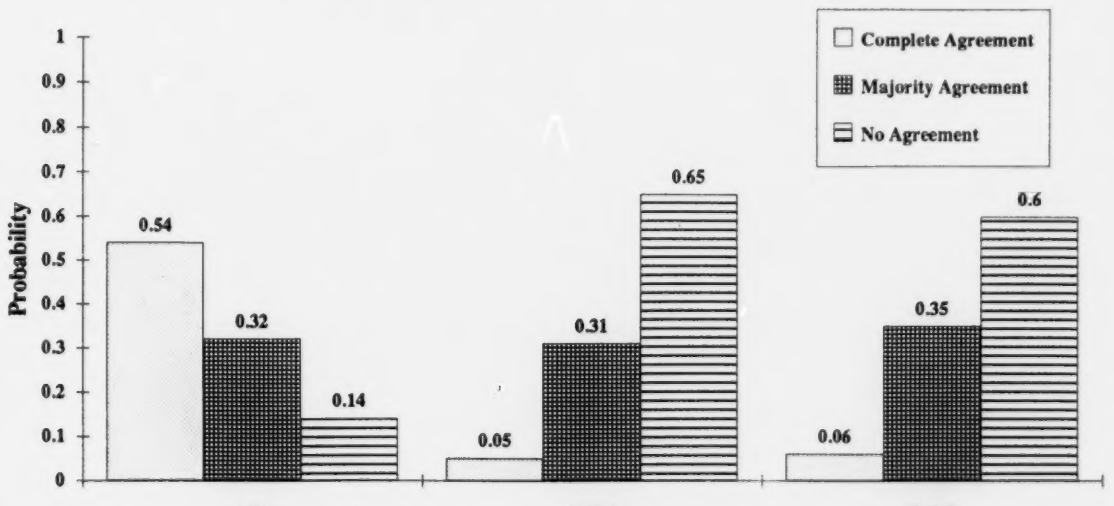
GRAPH 3-4: PROBABILITIES OF REACHING COMPLETE AGREEMENT BY RECOMMENDED TREATMENT MODALITY



To more closely examine the different levels of agreement, the Independent Ideal recommendations were examined by modality. When a modality was recommended, the probabilities that the two other panelists agree (complete agreement), only one other panelist agrees (majority agreement), or neither of the two panelist agrees (no agreement) is shown by modality in Graph 3-5.

When Inpatient is recommended, there is a 0.54 chance that the two other panelists will concur; there is a 0.32 chance that only one of the other two panelists will agree. Combining these two probabilities, when Inpatient is recommended, there is an 0.86 (0.54 + 0.32) chance that at least one of the other two panelists will also recommend Inpatient treatment. There is only a 0.14 probability that the other two panelists will disagree. The probabilities of the two other panelists agreeing when Intensive Outpatient or Regular Outpatient is recommended is much lower (0.05 and 0.06, respectively) than when Inpatient is recommended. This might suggest that there is less agreement regarding the placement of adolescents in outpatient treatment programs than in inpatient treatment programs.

GRAPH 3-5: PROBABILITIES OF REACHING SOME LEVEL OF AGREEMENT BY RECOMMENDED IDEAL TREATMENT MODALITY IN THE INDEPENDENT REVIEW

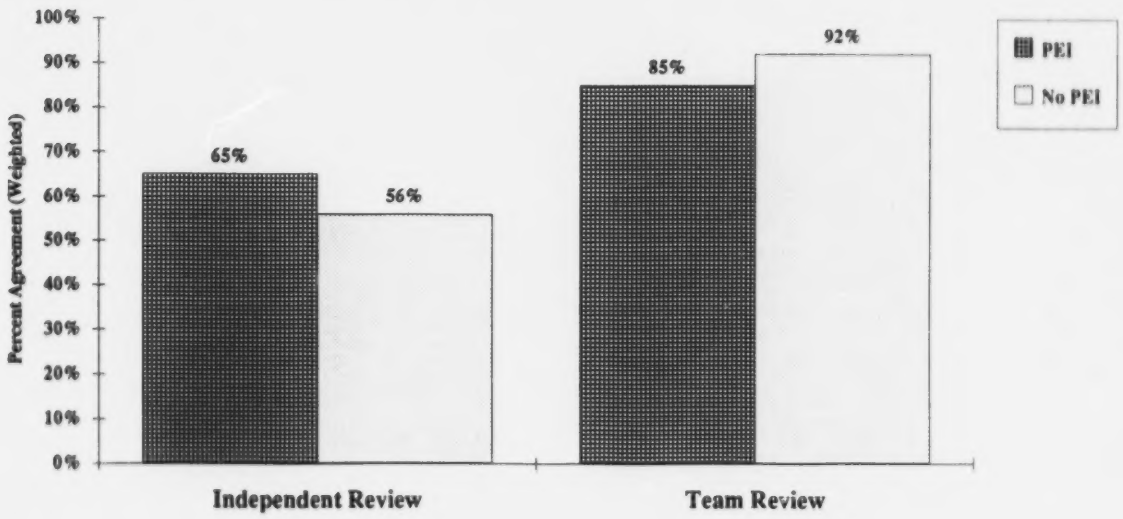


Agreement for Cases With and Without the Personal Experience Inventory (PEI)

The PEI is a standard assessment tool that was required for all intake assessments in the last biennium. Though no longer required, many treatment facilities continue to use it. The 72 cases were selected irrespective of inclusion of the PEI. Random selection resulted in 43% of the cases including PEI results. For those cases with PEI results, only the summary sheet was provided to the panelists.

Graph 3-6 illustrates the level of agreement (weighted) among team members for cases with and without PEI results. As with graphs 3-1 through 3-3, weighted values were used to account for probability of obtaining complete agreement. In both the Independent and Team Reviews, there was no statistically significant difference in the level of agreement for cases with and without the PEI. The presence of the PEI in a case does not affect the level of professional agreement. (Unweighted analysis is in Appendix C.)

GRAPH 3-6: LEVEL OF AGREEMENT FOR IDEAL PLACEMENT AMONG TEAM MEMBERS FOR CASES WITH AND WITHOUT THE PEI

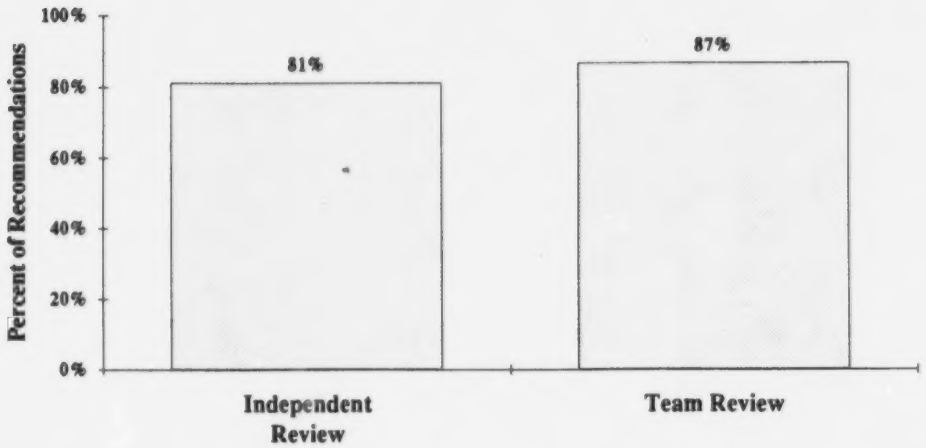


During the Team Reviews, the moderators asked the panelists if the PEI information was helpful in making placement decisions for those cases with PEI results. In 48% of the cases, the panelists said the results were helpful.

Agreement Between Realistic and Ideal Placements

Comparing individual treatment recommendations for realistic and ideal placements showed a high level of correspondence, in both the Independent and Team Reviews (Graph 3-7). In 81% of the cases in the Independent Review, the panelists recommended the same treatment for realistic and ideal placements, whereas in the Team Review, 87% of the cases were recommended for the same treatment. This may suggest that most services are available across the state; therefore, there is little difference between what should ideally take place, and what would be realistically recommended. However, this may also suggest that the panelists were not differentiating between realistic and ideal as rigorously as they actually would in the field.

GRAPH 3-7: PERCENT OF CASES RECOMMENDED BY PANELISTS FOR THE SAME TREATMENT FOR REALISTIC AND IDEAL PLACEMENTS

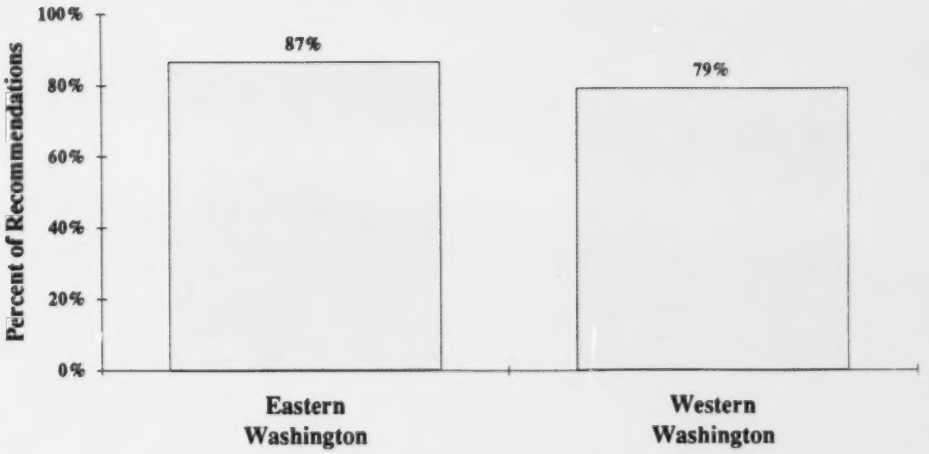


When the panelists were queried about this in the group meeting, they explained that often the difference between the two placements was not in the treatment modality selected, but in the duration of treatment suggested (ideal almost always being longer). Thus, they ordinarily can place a client in their treatment of choice, but for less time than would be desired (see "Level of Agreement on Placement Durations" in this section). In addition, they suggested that clients living in Western Washington had nearly all resources currently available to them, whereas those in Eastern Washington had fewer options available.

Regional Differences in Agreement for Realistic and Ideal Placements

Following the panelists' suggestion, we looked for regional variations in the rate of agreement between realistic and ideal placement recommendations. The panelists were divided by the region of the state from which they came. Four panelists work in Eastern Washington, and the remaining 11 work in Western Washington. If all treatment options were not available in Eastern Washington, then it would be expected that the four that work east of the mountains would have less correspondence for realistic and ideal placements, than the 11 west of the mountains. However, Graph 3-8 shows there was no statistically significant difference between the two regions. The four panelists in Eastern Washington selected the same treatment for realistic and ideal placements in 87% of the cases, whereas those in Western Washington selected the same treatment in 79% of the cases.

GRAPH 3-8: REGIONAL DIFFERENCES IN THE PERCENTS OF CORRESPONDENCE BETWEEN REALISTIC AND IDEAL PLACEMENTS IN THE INDEPENDENT REVIEW



The panelists were then divided by metropolitan and non-metropolitan work locations. Again no difference was found. Both groups recommended the same treatment for realistic and ideal conditions in 81% of the cases. We are unable to confirm geographic differences in the level of agreement between the realistic and ideal placement recommendations.

Level of Agreement on Placement Durations

When the panelists reviewed the assessments in the Independent and Team Reviews, they were asked to determine the duration of primary treatment. The overall mean recommended duration of treatment for realistic placements was 3.2 months. For ideal placements this increased one month to 4.2 months.

Table 3-2 shows the recommended mean duration of treatment by modality for those cases recommended for the same treatment under realistic and ideal conditions in the Independent Review. (Note: 81% of the cases in the Independent Review were recommended for the same treatment modality- Graph 3-7.)

TABLE 3-2: MEAN DURATION OF TREATMENT WHEN TREATMENT WAS THE SAME FOR REALISTIC AND IDEAL PLACEMENTS, INDEPENDENT REVIEW

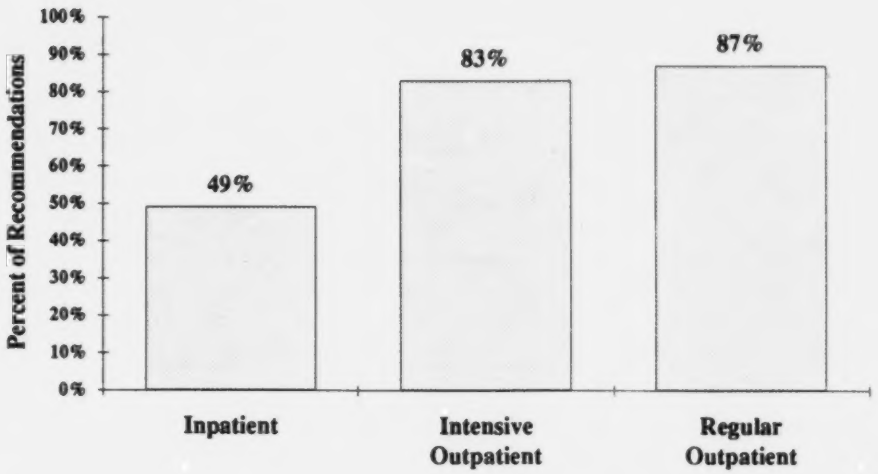
TREATMENT MODALITY	REALISTIC PLACEMENT	IDEAL PLACEMENT	PERCENT INCREASE
Inpatient (N=140)	2.0 months	3.2 months	65%
Intensive Outpatient (N=48)	5.6 months	6.6 months	18%
Regular Outpatient (N=49)	5.2 months	5.6 months	7%

The mean recommended duration increased for all three treatment modalities from realistic to ideal. The increase was statistically significant for Inpatient and Intensive Outpatient treatment only. This suggests the need for an increase in the length of treatment available for these two modalities.

Table 3-2 also shows that clients recommended for Intensive Outpatient treatment were recommended for the longest duration of treatment, for both realistic and ideal placements. Inpatient recommendations were for the shortest length of time. This is similar to actual treatment durations, where Inpatient clients generally receive one or two months of primary treatment, and Outpatient treatment tends to be for several months.

In 68% of the cases in the Independent Review, the recommended primary treatment duration was the same for realistic and ideal placements. However, the level of agreement between realistic and ideal treatment duration differed by modality. As Graph 3-9 illustrates, there was less agreement between realistic and ideal placements on treatment duration for Inpatient clients than for Intensive and Regular Outpatient clients. For example, in 49% of the cases recommended for Inpatient treatment, the recommended duration was the same for realistic and ideal placement.

GRAPH 3-9: LEVEL OF AGREEMENT ON TREATMENT DURATIONS FOR REALISTIC AND IDEAL PLACEMENTS (INDEPENDENT REVIEW)



In all but one case, when the duration of treatment for Realistic and Ideal placements did not agree, the panelists recommended longer treatment for Ideal placements. Graph 3-9 shows that differences in the prescribed ideal and realistic duration recommendations for Intensive Outpatient are infrequent. The statistically significant increase (of 18%) from realistic to ideal placements (Table 3-2) for Intensive Outpatient recommendations is the product of a few cases with a large difference in duration, while the majority of duration recommendations for Intensive Outpatient is the same for realistic as ideal.

Level of Agreement for Common Cases

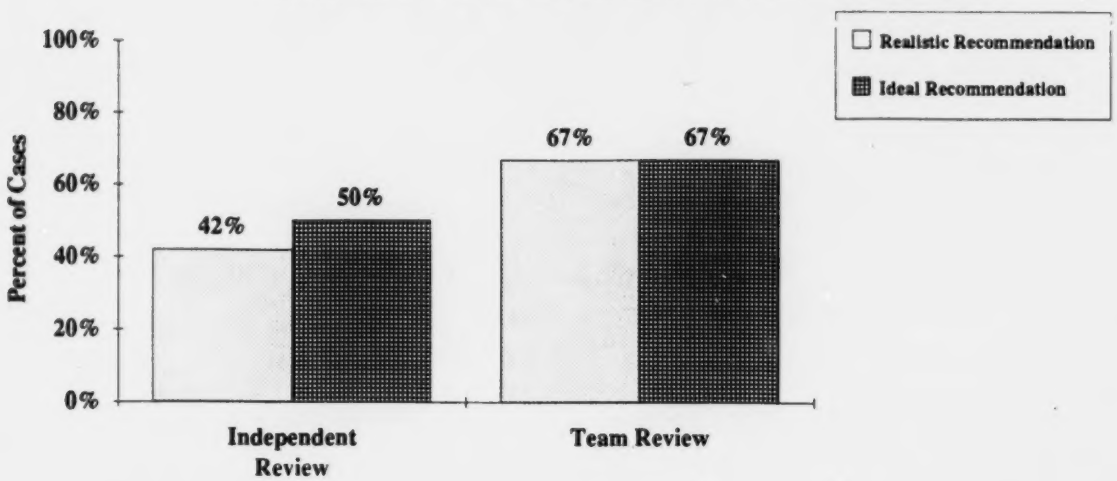
Twelve cases were reviewed by all 15 panelists. By looking at these common cases, a better measure of agreement in the field can be obtained. Instead of focusing on the level of agreement of a team of three panelists, significant agreement within the entire group of fifteen panelists is examined. Agreement among fifteen panelists provides a more reliable measure of agreement, than among three panelists.

Significant agreement was determined by comparing the distribution of the fifteen panelists' individual case recommendations to the average distribution for all common case recommendations in the Independent Review. (See Appendix D for the distribution of recommendations for all 12 common cases.)

Graph 3-10A shows that for realistic placements in the Independent Review, panelists had a significant level of agreement in 42% (five out of twelve) of the cases. For the ideal placements, there was significant agreement in 50% (six out of twelve) of the cases. Thus, there was slightly more agreement in the ideal placements than in the realistic placements. For the Team Review, the percentage of cases in which significant agreement was reached increased to 67% (8 out of 12) for both realistic and ideal placements.

These increases are similar to those observed when consensus within the teams of three was investigated. Overall, however, the percentages are somewhat lower than those obtained by analyzing consensus within the teams of three. This is not surprising, given that it is more difficult to reach a significant level of agreement in a group of fifteen than it is to have consensus in a team of three. It is also important to recognize that agreement is being measured in two different ways: within teams of three and among the fifteen panelists.

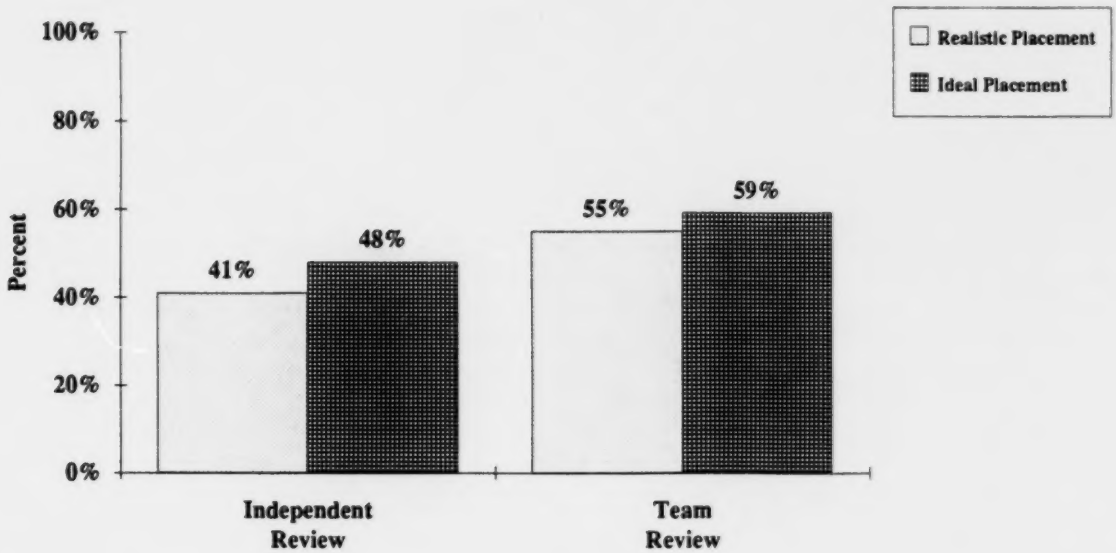
GRAPH 3-10A: PERCENTAGE OF COMMON CASES IN WHICH SIGNIFICANT AGREEMENT WAS REACHED, BY ALL 15 PANELISTS



Note: "Significant Agreement" among the panelists was determined by using multiple t tests (p=0.05) on the distribution of fifteen placement recommendations for each common case.

Common cases were also analyzed by the level of pairwise agreements there were among the fifteen panelists. That is, for each case, we looked at how many times two panelists agreed with each other on any modality. There are 105 possible ways any 2 panelists in a group of fifteen can agree. Graph 3-10B shows the percentage of pairwise agreements obtained (regardless of modality) out of the 1260 (105 x 12 cases) possible pairwise agreements. These results are very similar to those observed in Graph 3-10A.

GRAPH 3-10B: PERCENTAGE OF PAIRWISE AGREEMENTS IN COMMON CASES



These two graphs, 3-10A and 3-10B, show similar levels of agreement to that found when examining weighted agreement within teams of three.

C: APPROPRIATENESS OF ACTUAL PLACEMENTS

Information on how the 72 clients were actually placed was known, but not shared with the panelists. Comparing recommended treatment with actual placement serves as a proxy measure for the appropriateness of actual treatment. If a high level of concordance was achieved, this would suggest the current system closely approximates the panelists' recommended treatment. Thus actual placements could be regarded as appropriate.

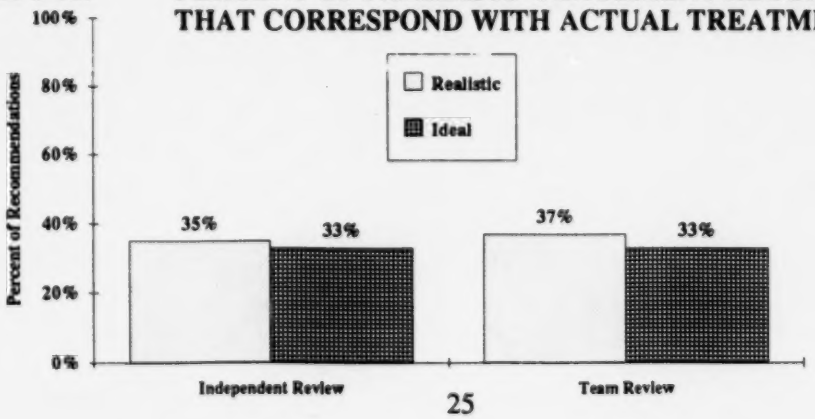
It is important to note, however, that actual recommended treatment is not known, but actual received treatment is. Many factors effect the eventual treatment a client receives. Recommended treatment is only one of these factors. In addition to this, actual placement will be strongly influenced by availability of a particular program, as well as willingness of the client to enter a particular treatment. The panelists reported a high refusal rate by adolescents to enter Inpatient treatment. Often, teens are placed in Intensive Outpatient programs because of their resistance to Inpatient settings. Thus, caution must be exercised when comparing panelists' recommendations to actual placements.

Comparison of Recommended Placements with Actual Treatment Received

In the Independent and Team Reviews, the placement recommendations made by the panelists were compared to the actual treatment the clients received. All recommendations for "Other" treatment (not Inpatient, or Intensive or Regular Outpatient) were excluded from this analysis. Graph 3-11 shows that for all realistic recommendations made in the Independent Review, 35% were for the same treatment the clients actually received. In other words, 65% were recommended for treatment that differed from what the clients actually received. When panelists recommended the clients for ideal treatment in the Independent Review, again there was little agreement with the actual treatment the client received (37%). Similar results were found in the Team Review.

While agreement between recommended placement and actual treatment seems low, this may be due in part to the other factors mentioned above which affect actual placements, such as client refusal.

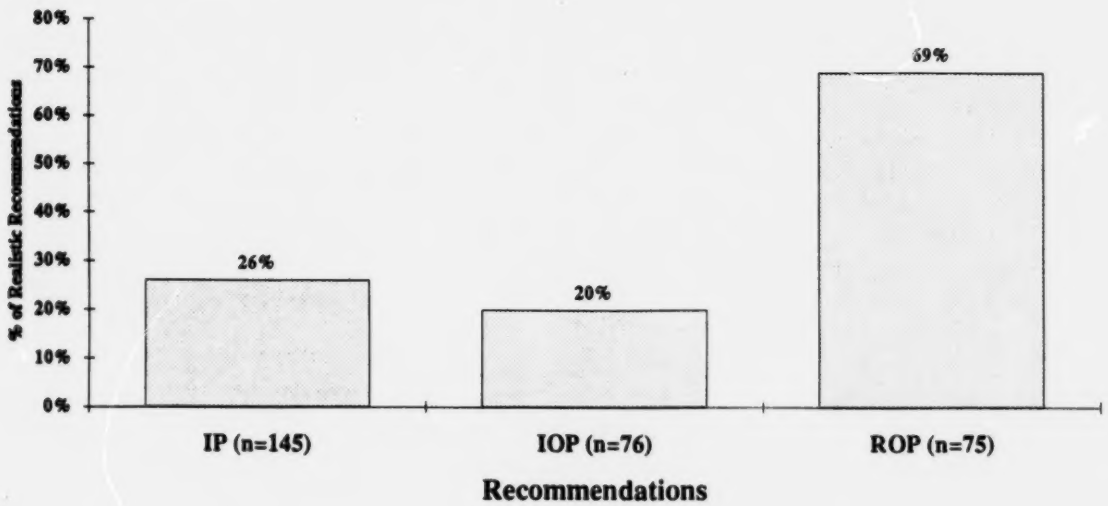
GRAPH 3-11: PERCENT OF PANELISTS' PLACEMENT RECOMMENDATIONS THAT CORRESPOND WITH ACTUAL TREATMENT RECEIVED



Correspondence Between Recommended Placements and Actual Treatment, by Modality

As was shown in Graph 3-11, 35% of the realistic recommendations made in the Independent Review corresponded with the actual treatment received by the clients. Differences were observed for the three treatment modalities, when panelists' recommendations were compared to actual treatment received. Graph 3-12 illustrates that 26% of the 145 Inpatient recommendations made by the panelists in the Independent Review actually received Inpatient treatment. The converse of this is that 74% of the clients recommended for Inpatient treatment actually received some other form of treatment. Twenty percent of the 76 cases recommended by the panelists for Intensive Outpatient placement actually received this treatment. While the majority cases, 69%, recommended for Regular Outpatient placements actually received Regular Outpatient treatment. Thus, most of the cases recommended for Inpatient and Intensive Outpatient treatment did not actually receive these treatments.

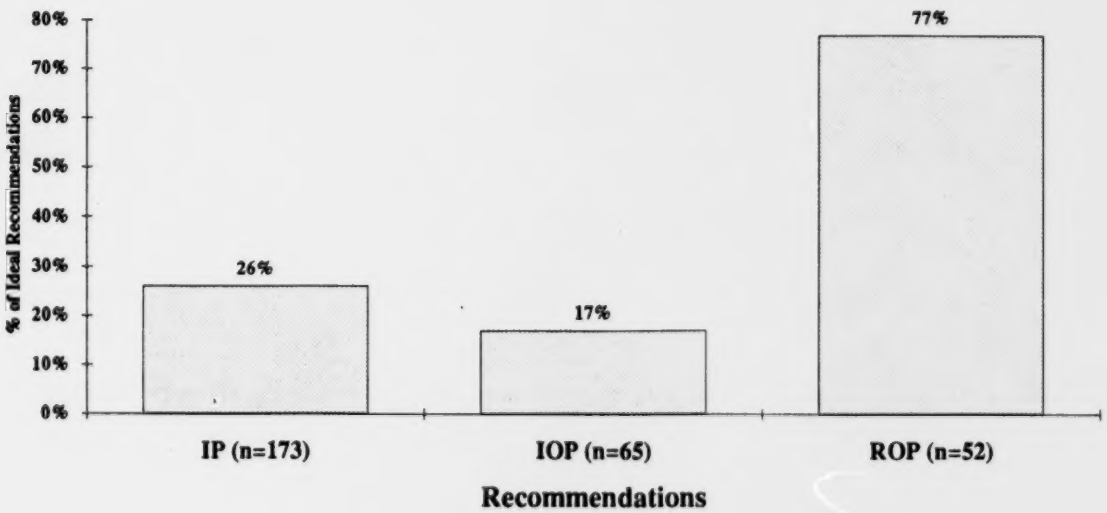
GRAPH 3-12: PERCENT OF REALISTIC RECOMMENDATIONS THAT CORRESPOND WITH ACTUAL PLACEMENTS, IN THE INDEPENDENT REVIEW



Graph 3-13 illustrates the same information as that presented in Graph 3-12, but for ideal recommendations made in the Independent Review. A very similar relationship is evident. Again, 26% of the 173 clients recommended for Inpatient treatment, given ideal circumstances, were actually placed in Inpatient treatment; 17% of the recommendations for Intensive Outpatient actually received Intensive Outpatient treatment; and 77% of the recommendations for Regular Outpatient actually received Regular Outpatient treatment.

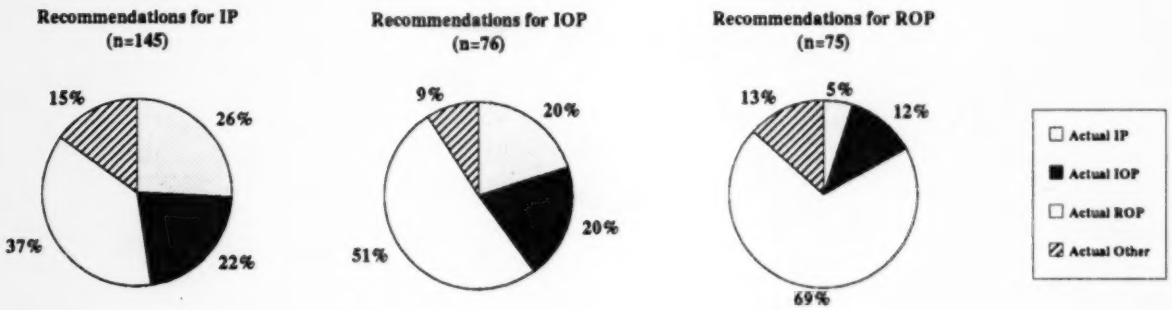
The similarities between the graphs for realistic and ideal recommendations (Graphs 3-12 and 3-13) are not surprising, given the high level of agreement between these two placement recommendations made by the panelists. Further analysis of the Team Review recommendations also reveals very similar findings. The small differences between realistic and ideal recommendations would also indicate that treatment availability probably accounts for only a small part of the difference between actual and recommended treatment.

GRAPH 3-13: PERCENT OF IDEAL RECOMMENDATIONS THAT CORRESPOND WITH ACTUAL PLACEMENTS, IN THE INDEPENDENT REVIEW

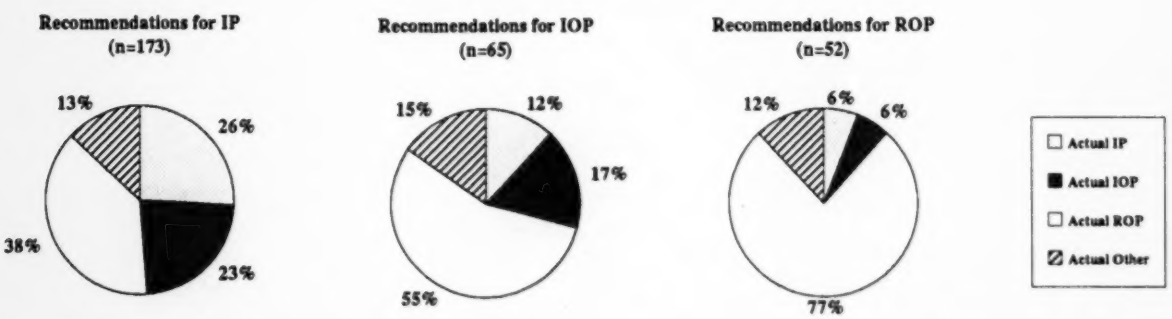


Graphs 3-14a and 3-14b show, for the Independent review, how the clients recommended for a particular treatment were distributed for actual treatment. (Graph 3-14a shows the distribution for realistic recommendations, and Graph 3-14b shows the distribution for ideal recommendations.) Each pie chart illustrates the recommendations for a particular modality. In Graph 3-14a the first pie chart, for Inpatient recommendations in the Independent Review, shows that 26% of the clients were actually placed in Inpatient treatment, while 22% actually received Intensive Outpatient treatment, 37% actually received Regular Outpatient treatment, and 15% received some other form of treatment (usually education). The second and third pie charts illustrate the same concept for cases recommended by the panelists for Intensive Outpatient treatment and Regular Outpatient treatment, respectively.

GRAPH 3-14a: DISTRIBUTION OF ACTUAL PLACEMENTS FOR INDEPENDENT REALISTIC RECOMMENDATIONS



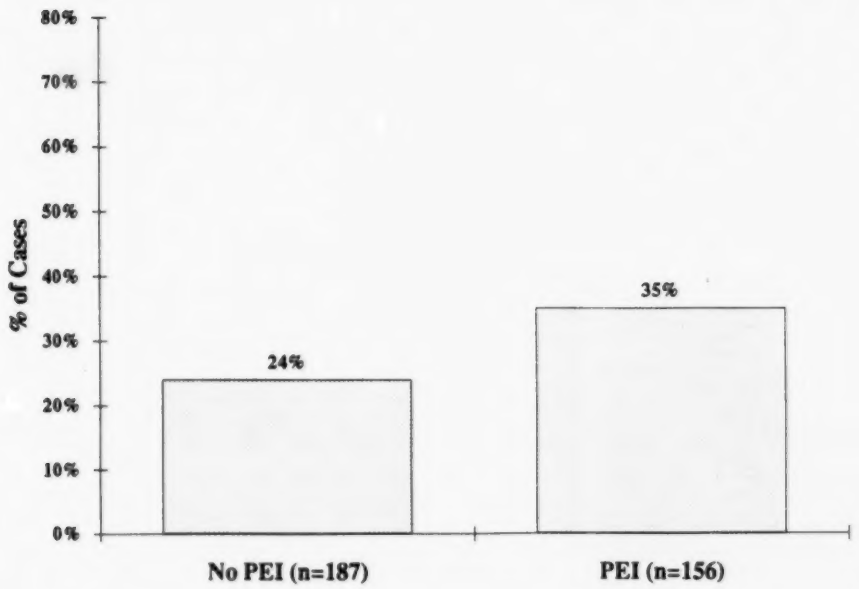
GRAPH 3-14b: DISTRIBUTION OF ACTUAL PLACEMENTS FOR INDEPENDENT IDEAL RECOMMENDATIONS



Correspondence Between Recommended Placements and Actual Treatment, For Cases With and Without PEI Results

In the Independent Ideal Review, all panelists' recommendations were compared to the actual treatment received by the clients. The cases were divided by presence or absence of PEI results to determine the importance of the PEI in making placement decisions. As Graph 3-15 reveals, in 24% of the 187 case reviews without PEI results, the placement recommendation and actual treatment was the same. When PEI results were available (in 156 case reviews) there was a higher level of correspondence between recommended and actual placements. This difference was statistically significant. Although the results reported in Graph 3-6 indicate the PEI does not influence the level of agreement, results reported in Graph 3-15 indicate that the PEI was, in fact, helpful in making placement decisions.

GRAPH 3-15: PERCENTAGE OF CASES FOR WHICH INDEPENDENT IDEAL RECOMMENDATIONS AND ACTUAL PLACEMENTS WERE THE SAME, BY PRESENCE OR ABSENCE OF PEI RESULTS



D: FACTORS CRITICAL FOR PLACEMENT DECISIONS

For each case in the Independent Review, the panelists rank ordered the five most important factors influencing their placement decision. This was done separately for both their realistic and ideal placement decisions. In the Team Review, if all three panelists agreed on the three most important factors this was recorded. Otherwise, each panelist indicated one factor. For a list of all factors, see Appendix A.

The observers in the debriefing, and the panelists in the group discussion following the Team Review, reported minimal attention to discussing the factors in the Team Review. The majority of the teams simply recorded the top choice of each panelist. For this reason, the evaluation of the factors will focus largely on the Independent Review.

Distribution of Factors

For the Independent and Team Reviews, the selected factors were distributed by category. As Table 3-7 shows, there was very little difference in the distribution of selected factors for the Independent and Team Reviews. Drug History factors were cited most frequently as critical in making placement decisions. The categories Family History and High Risk Behavior were stated to be the next most important considerations for placement. The factors identified least often as critical related to Medical Concerns and Level of Personal Development.

TABLE 3-7: DISTRIBUTION OF FACTORS

Category	Independent Review		Team Review	
	Realistic Placement (N=1800)	Ideal Placement (N=1800)	Realistic Placement (N=1800)	Ideal Placement (N=1800)
Drug History	37%	34%	41%	40%
Family History	17%	18%	16%	18%
High Risk Behavior	14%	13%	11%	12%
Social Background	11%	10%	5%	6%
Personal Development	3%	2%	2%	2%
Medical Concerns	2%	3%	2%	2%
Other	7%	8%	8%	8%
No Response	10%	13%	14%	13%
TOTAL	**100%**	**100%**	**100%**	**100%**

Note: 15 panelists x 24 cases x 5 factors = 1800 total factors selected.

Comparison of Factors for Ideal and Realistic Placements

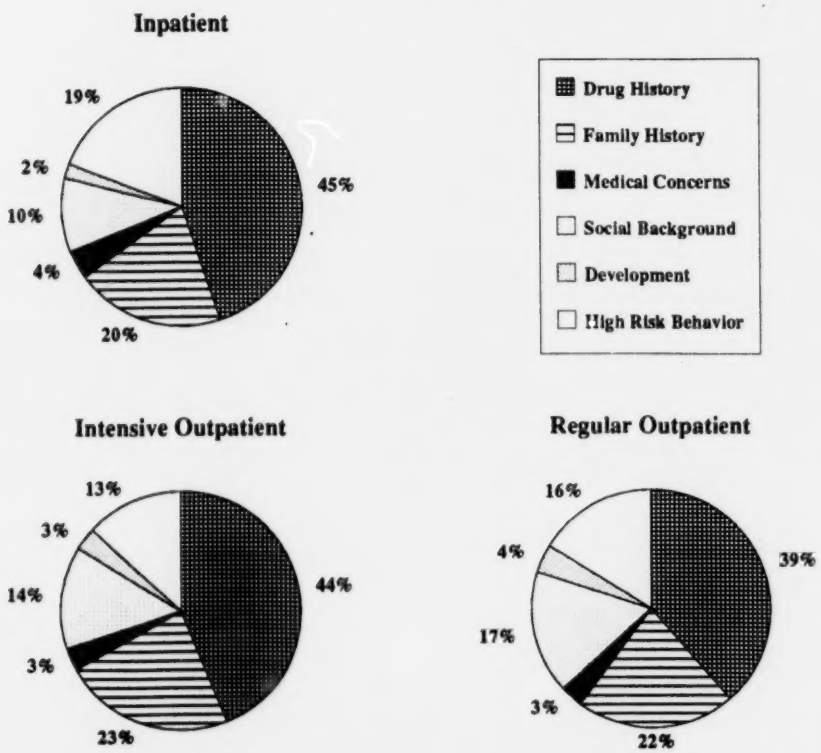
Table 3-7 shows there was very little difference between the factors identified as most important for realistic and ideal placement. Drug History factors were identified most often, and Personal Development and Medical Concerns were identified least often. When the realistic and ideal factors were compared one-to-one for the Independent Review, there was a match 79% of the time.

Selected Factors by Treatment Modality

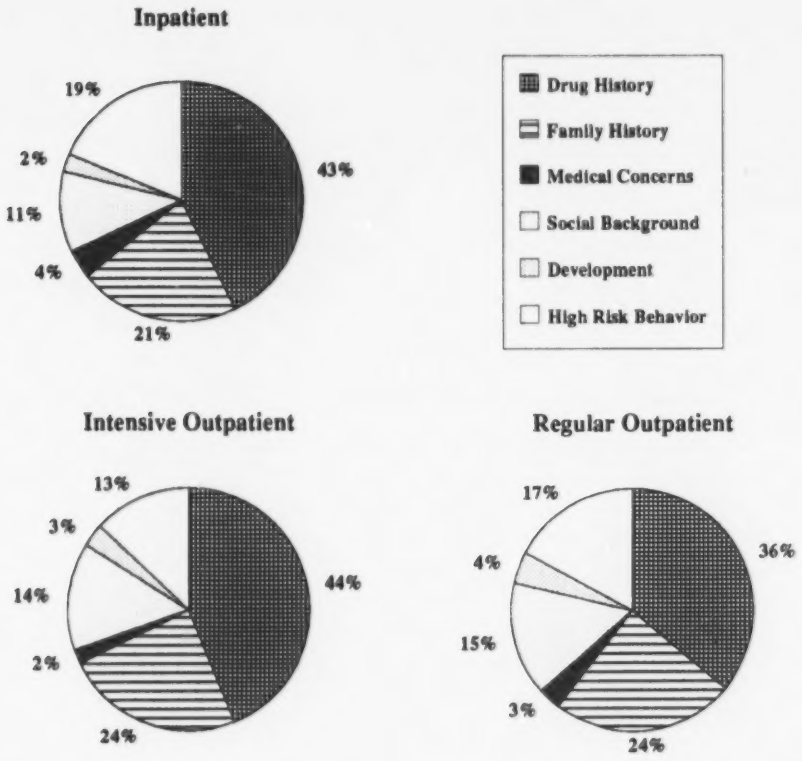
The factors identified as most important by the panelists were examined by treatment modality, for the Independent Review. The selected factors for all clients recommended for Inpatient treatment were grouped together, and then distributed by category. This was done for the other two treatment modalities as well.

Graphs 3-16 and 3-17 present three pie charts, one for each treatment modality. Each pie chart shows the distribution of selected factors by category. (The pie charts, however, do not include the category "Other" and "No Response".) For this analysis, treatment placement for a case was defined as the placement selected by the panelists. Graph 3-16 illustrates critical factors for realistic placement in the Independent Review, and Graph 3-17 presents critical factors for ideal placement in the Independent Review.

GRAPH 3-16: FACTORS CITED, BY RECOMMENDED REALISTIC PLACEMENTS, IN THE INDEPENDENT REVIEW



GRAPH 3-17: FACTORS CITED, BY RECOMMENDED IDEAL PLACEMENTS, IN THE INDEPENDENT REVIEW



Comparing the distribution of factors presented in Table 3-7 with the distribution of factors, by treatment modality, presented in the pie charts (Graphs 3-16 and 3-17), shows many similarities. Across the three modalities, Drug History factors are cited most frequently as being critical in making placement decisions. However, for both realistic and ideal placements, Drug History was cited more often for Inpatient placements than for Regular Outpatient placements. This difference was statistically significant for both realistic and ideal placements. (Note: The distribution of factors for which this was calculated differs from that presented in the pie charts. This is because "Other" responses and no responses were included in calculating the total.)

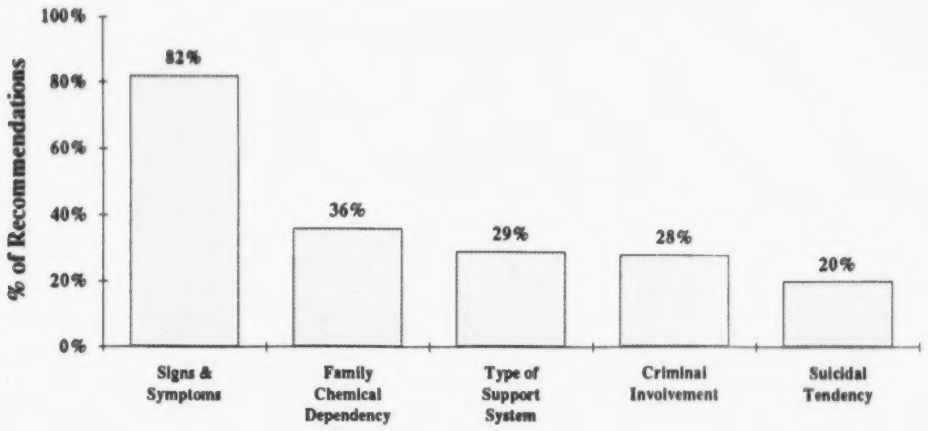
Medical concerns, including such factors as pregnancy and drug-related medical problems, were cited infrequently for the three treatment modalities. It might be expected that clients would be placed more often in Inpatient treatment due to medical problems, but the data do not support this.

The Five Most Often Cited Factors for Each Modality

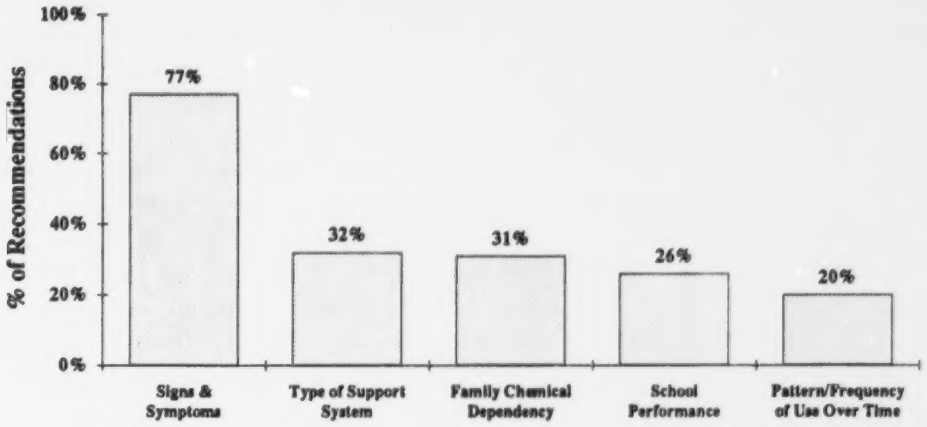
As shown in Graphs 3-16 and 3-17, when factors were analyzed by categories, there was very little difference in the factors cited in each modality. To further examine possible differences between critical factors by modality, the five most important individual factors (not by category, but of the list of 41 factors) are extracted.

Graph 3-18 shows, in order, the five most frequently cited factors when Inpatient was recommended. That is, in 82% of the cases recommended for Inpatient, "signs and symptoms" was a factor in making that recommendation. In fact, Graphs 3-19 and 3-20 show that "signs and symptoms" was also the most often cited factor for Intensive Outpatient and Regular Outpatient placement recommendations. However, it is also important to note that the most frequently cited factors do vary slightly for the different modalities. For instance, "school performance" was cited often for both outpatient modalities, but it was not for Inpatient. "Criminal involvement" was frequently cited for Inpatient and Regular Outpatient, but not as often in Intensive Outpatient.

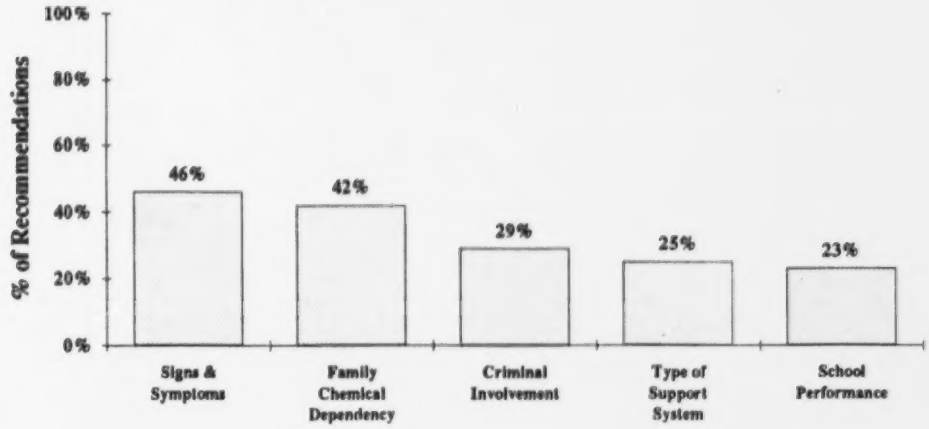
GRAPH 3-18: FACTORS CITED MOST OFTEN FOR INPATIENT RECOMMENDATIONS



GRAPH 3-19: FACTORS CITED MOST OFTEN FOR INTENSIVE OUTPATIENT RECOMMENDATIONS



GRAPH 3-20: FACTORS CITED MOST OFTEN FOR REGULAR OUTPATIENT RECOMMENDATIONS

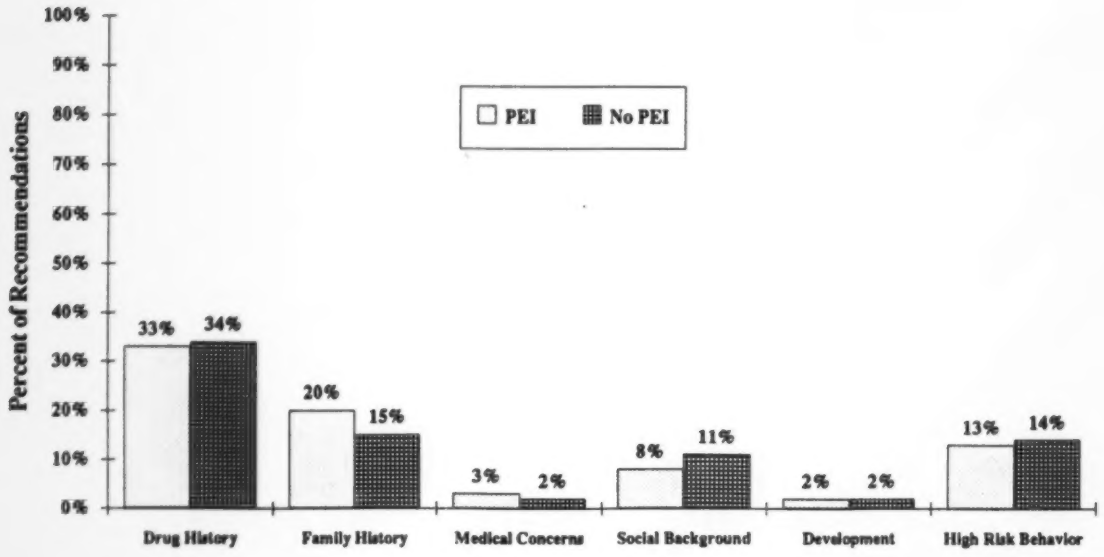


Through further analysis, more difference between the factors cited for each of the modalities were found. Although they were not the most often cited factors it is interesting to find that "attempts at abstinence" was considered more often in Inpatient (11%) and Intensive Outpatient (12%) than it was for Regular Outpatient (2%). Not surprisingly, a client's "history of running away" was a factor more often cited in making an Inpatient (12%) placement recommendation than in making either an Intensive Outpatient (2%) or a Regular Outpatient (4%) recommendation. Furthermore, "self-destructive behavior" proved to be more important for Inpatient (15%) than for Intensive Outpatient (9%) and Regular Outpatient (4%) treatment recommendations.

Factors Cited in Cases With and Without the Personal Experience Inventory (PEI)

To further test the effects of the PEI on the placement decision process, the factors cited for cases with and without the PEI were analyzed. Graph 3-21 shows that there was generally very little difference between cases with and without the PEI in the factors cited (by category). A statistically significant difference observed was in the category of "Family History." This category was cited in 20% of the cases with the PEI and in 15% of the cases without the PEI. This may suggest that important information regarding a client's family history is often extracted with the use of the PEI. For the other categories the differences were not significant.

GRAPH 3-21: FACTORS CITED BY CATEGORY FOR CASES WITH AND WITHOUT THE PEI



Note: The percents do not add to 100% because the "Other" category and "No Responses" are not shown

CHAPTER IV: DISCUSSION

A: STUDY LIMITATIONS

Several limitations to this study should be acknowledged when considering the results.

One of the basic premises of the Peer Panel Review is that the panelists are representative of the substance abuse counselors in Washington State. As was discussed in Chapter II on Study Design, the panelists were very carefully selected, based on the six Regional Administrators' recommendations. However, of the fifteen panelists, eight were currently working as treatment program administrators. This over-selection of administrators probably had little effect on the study outcome, yet it should be recognized that they most likely have a greater breadth of experience than the average treatment counselor.

The chief concern of the panelists regarding the study is that it is unrealistic to make treatment placement decisions based solely on written materials. The one-on-one interaction with the adolescent client provides a great deal of information that is impossible to document on paper. Thus, the panelists believed they were making their decisions based on a very limited amount of information.

The assessment files reviewed differed significantly in their content. Some files contained three or four pages of scanty information, while others provided numerous pages of detailed material. In reviewing some of the more sketchy files, the observers reported a high level of frustration for the panelists, and sometimes less attention and time was spent on these cases. Often, more time was spent discussing the lack of information, than appropriate treatment.

The observers also believed that some of the differences in judgment had to do with the moderators. The moderators had different styles of presenting information, managing discussions, and participating personally.

Further evaluation of the observer reports identified other limitations. Initially, there was disagreement on the definitions of the treatment modalities. These differences were discussed within the teams, but not within the entire panel. Different teams may have been using different definitions. The observers also noted that some of the panelists appeared to view achieving consensus as a goal. This may have led to a higher level of agreement than might otherwise have been achieved.

B: IMPLICATIONS AND RECOMMENDATIONS

The high level of correspondence between the proposed ideal and realistic placements implies that the panelists generally believe that the care they see as needed, by modality, is available in the areas where they work. No regional or metropolitan/non-metropolitan differences were found. However, there were differences between realistic and ideal placements regarding treatment durations. For Inpatient and Intensive Outpatient treatment, the mean recommended duration was significantly longer for ideal treatment than realistic treatment. This strongly suggests a need to increase available treatment length for these two modalities. Little difference in duration was found between realistic and ideal placements for Regular Outpatient clients.

Most panelists expressed disappointment and surprise at the great variability in the different assessment forms. They felt some of the assessments were far too general and non-specific, and they were concerned the clients might be inappropriately placed due to a lack of detailed information being collected. When the observers' notes were examined, the most common remark was the lack of information available in the files. In general, the panelists felt stricter guidelines on what to include in an assessment form should be developed and implemented by DASA. Furthermore, some panelists felt a standardized assessment form (not the PEI) should be developed for use at all adolescent treatment facilities.

Throughout the two-day Team Review, the panelists frequently mentioned the benefits gained from discussing and sharing their ideas regarding treatment. The panelists had the opportunity to discuss with their colleagues treatment alternatives, different philosophies, and treatment options available around the state. Many of the panelists left the meeting having learned about new and lesser-known resources available. In an anonymous evaluation completed after the meeting, 88% of the panelists stated more seminars and training geared toward standardizing assessments and intakes would be helpful.

The adolescent substance abuse treatment field is still quite new. The lack of consistency regarding treatment placement that was present in this study strongly suggests the need for further training and education around assessment issues. At present, there is little standardization of the assessment process. Developing and imposing detailed guideline for doing assessments would help standardize and improve the field of adolescent treatment.

C: FUTURE DIRECTIONS

If this study were to be replicated, there are several methodological changes that might be helpful.

Increase the number of panelists

Common cases were used to determine the strength of significance found for level of agreement among all 15 panelists. However, using only 15 panelists made it difficult to obtain enough statistical power to examine significant agreement. Using a larger number of panelists would have made this analysis more reliable. Obtaining agreement among 30 panelists, rather than only 15, would provide a more reliable level of agreement.

Revise the team review meeting

The validity and value of the Team Review findings are questionable. The intent of having the panelists get together to discuss the cases was to determine if a higher level of agreement could be achieved than when they independently reviewed the cases. Though a higher level of agreement was achieved in the Team Review, the reasons for this are difficult to ascertain. As discussed in this report, it is possible that panelists agreed with each other because of the tendency to go along with the majority. The independent reviews more nearly represent the real world situation of client assessments than do team reviews. Team reviews would seem to be useful in future research mainly to gain insight into what experts might suggest as a group and to improve understanding of the elements involved in assessments.

One valuable outcome of the Team Meeting was the general discussion with all panelists that followed the case review. They provided valuable insight into the placement process, both for us and for each other. This meeting also provided a time to learn about different adolescent treatment facilities available around the state.

Modify PEI analysis

Examination of the utility of the PEI for assisting in the placement process is very important. A more structured experiment would have been helpful. Future studies might have panelists evaluate cases excluding PEI summary data, and then later provide panelists with PEI results for the same cases. Comparing the same cases excluding, and then including, PEI data would provide greater certainty of the PEI's value.

Obtain actual counselors' placement recommendations

This study compared panelists' recommendations with actual placements. This provides a measure of how closely actual placements match ideal recommendations. However, it would have been appropriate and informative to also compare actual recommendations with both actual placements and panelists' recommendations.

Need more explicit term definitions

One problem with the study is that the terms used were not always clearly defined. Several observers reported the panelists spent time in the team meetings defining terms. Clear definitions should have been agreed upon prior to the independent assessments. This would include defining the three treatment modalities, and the difference between ideal and realistic conditions. Likewise, the 48 factors should have been clearly defined. Some were quite vague, such as "signs and symptoms" and "type of support system". Either could have been interpreted from a positive or negative standpoint. This led to ambiguity in the interpretation.

Include education as a treatment option

In the procedural meeting, the panelists reported three common treatment options: Inpatient, Intensive Outpatient, and Regular Outpatient. In reviewing the cases, however, the panelists occasionally recommended education as an alternative to treatment, particularly for those cases with minimal drug use. Had education been an option listed on the evaluation form, the panelists may have selected it even more frequently.

Provide training for the moderators

The observers reported a great deal of variation in how the moderators led the discussions. Some were actively involved in directing the conversations, while others facilitated with a more objective approach. It is likely that this variation led to differences in focus, and possibly it influenced the level of agreement achieved. More consistency between the moderators may have been achieved if they had received training on how to conduct the discussions. Rather than using specialists from the adolescent substance abuse field, it may have been more helpful to have researchers serve as moderators.

Use observers familiar with the field

The observers reported difficulty following the discussions. This difficulty may have been reduced if the observers were more familiar with the field of adolescent treatment. A conscious decision was made to use observers from outside the field as a way of increasing their objectivity. However their lack of familiarity with the terms and jargons used, and issues discussed, impeded their ability to thoroughly report on the discussions. Using researchers as observers might overcome these obstacles.

REFERENCES

Owen, P.L. and L.R. Nyberg, "Assessing Alcohol and Drug Problems Among Adolescents: Current Practices," Journal of Drug Education, 13:249-254, 1983.

Winters, K., "The Need for Improved Assessment of Adolescent Substance Involvement", Journal of Drug Issues, 20(3), pp. 487-502, 1990.

APPENDIX A: FACTORS THE PANELISTS COULD SELECT ON THE EVALUATION FORM

DRUG HISTORY:	SOCIAL BACKGROUND:
Prior treatment experience	School performance
Length of use	Friends using
Type of drugs used	Client in gang
Age of first use	Physical violence common
Last use	Social functioning
Frequency of use	Peer relations
Method of use	
Signs and Symptoms	
Attempts at abstinence	**DEVELOPMENT:**
Tolerance level	
Pattern of use over time	Level of maturity
	Client's age
	Educational level
FAMILY HISTORY:	Developmental disability
	Learning disability
Type of support system	
Physical abuse	
Emotional abuse	**HIGH RISK BEHAVIOR:**
Sexual abuse	
Family chemical dependency	History of running away
Person in household	Criminal involvement
	Suicidal tendency
	Assaultive behavior
MEDICAL CONCERNS:	Self-destructive behavior
Drug-related medical problems	
Eating disorders	**OTHER:**
Medical problems	
Pregnant client	Mental health problems
Medication history	Motivation of client toward treatment
	Client's own statement re: problem

APPENDIX B: TREATMENT FACILITIES THAT PROVIDED CASES

Client cases were received from the following agencies for use in the Peer Panel Review:

ALPHA HOUSE\FORCE
4214 PORTLAND AVE
TACOMA WA 98404

AUBURN YOUTH SERVICES
816 F STREET SE
AUBURN WA 98002

CASCADE RECOVERY SERVICES
5630 S 296TH COURT
AUBURN WA 98001

CENTER FOR HUMAN SERVICES
17011 MERIDIAN AVE N
SEATTLE WA 98133

CENTRAL YOUTH & FAMILY SERVICES
1730 BRADNER PLACE S
SEATTLE WA 98144

COMMUNITY ALCOHOL & DRUG CENTER
1260 COMMERCE SUITE 2
LONGVIEW WA 98532

CONSEJO
3808 S ANGELINE ST
SEATTLE WA 98118

DAYBREAK OF SPOKANE
POST OFFICE BOX 8616
SPOKANE WA 99203

405 PROGRAM
1206 S 11TH ST STE 8
TACOMA WA 98405

NEW BEGINNINGS OF NW
600 NORTH 130TH
SEATTLE WA 98133

CHILD & FAMILY SERVICES
KITSAP MENTAL HEALTH SERVICES
500 UNION
BREMERTON WA 98312

PROJECT YOUTH RECOVERY
BENTON-FRANKLIN JUVENILE COURT
5606 W CANAL PLACE SUITE 106
KENNEWICK WA 99336

OLYMPIC COUNSELING CENTER
1215 REGENTS BLVD SUITES A & B
TACOMA WA 98466

PACIFIC TREATMENT ALTERNATIVES
1114 PACIFIC AVENUE
EVERETT WA 98201

PARKE CREEK
ROUTE 3 BOX 1120
ELENSBURG WA 98926

PIERCE COUNTY ALLIANCE
710 SOUTH FAWCETT
TACOMA WA 98402

RECOVERY NORTHWEST
391 NW STATE AVENUE
CHEHALIS WA 98532

RYTHER CHILD CENTER
2400 NORTHEAST 95TH
SEATTLE WA 98115

ST PETER'S CHEMICAL DEPENDENCY
4800 COLLEGE STREET SE
LACEY WA 98503

THURSTON-MASON COMM MENTAL HEALTH
112 EAST STATE STREET
OLYMPIA WA 98501

OLYMPIC CENTER
1603 E ILLINOIS
BELLINGHAM WA 98226

TOUTLE RIVER BOYS RANCH
2232 S SILVERDALE RD
CASTLE ROCK WA 98611

RUTH DYKEMAN CHILDREN'S CENTER
YOUTH & FAMILY SERVICES BRANCH
POST OFFICE BOX 66086
SEATTLE WA 98115

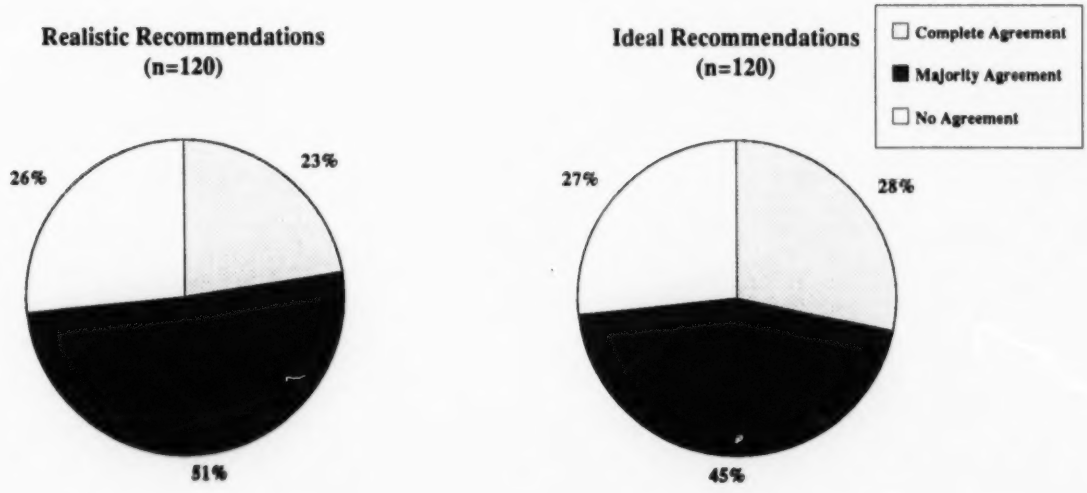
APPENDIX C: LEVEL OF PROFESSIONAL AGREEMENT AMONG PANELISTS (Unweighted Values)

When analyzing consensus it is important to take into account that the probability of reaching complete agreement is much smaller than reaching majority or no agreement in a team of three. There are only 4 outcomes that would result in a complete agreement: all three recommend either Inpatient, Intensive Outpatient, Regular Outpatient, or Other (usually education). However, a team of three can have a majority agreement with 16 different outcomes (for example, 2 IP with 1 IOP, or 2 IP with 1 ROP). Furthermore, there are 15 possible ways a team of three can result in "no agreement." Because the probability of reaching each type of agreement is not the same (IP:IOP:ROP = 4:16:15), weighted values are more appropriate. The raw percentages are presented here to show the effects of the weighting procedure.

Compared to the weighted values in Graph 3-1, Graph D-1 shows that the rate of majority agreement was higher in the Independent Review for both realistic (51%) and ideal (45%) placements, while complete agreement was lower. In the Team Review, complete agreement was the result most often found for both realistic (62%) and ideal (67%) placements.

GRAPH C-1a: LEVEL OF PROFESSIONAL AGREEMENT (UNWEIGHTED) IN PLACEMENTS

INDEPENDENT REVIEW



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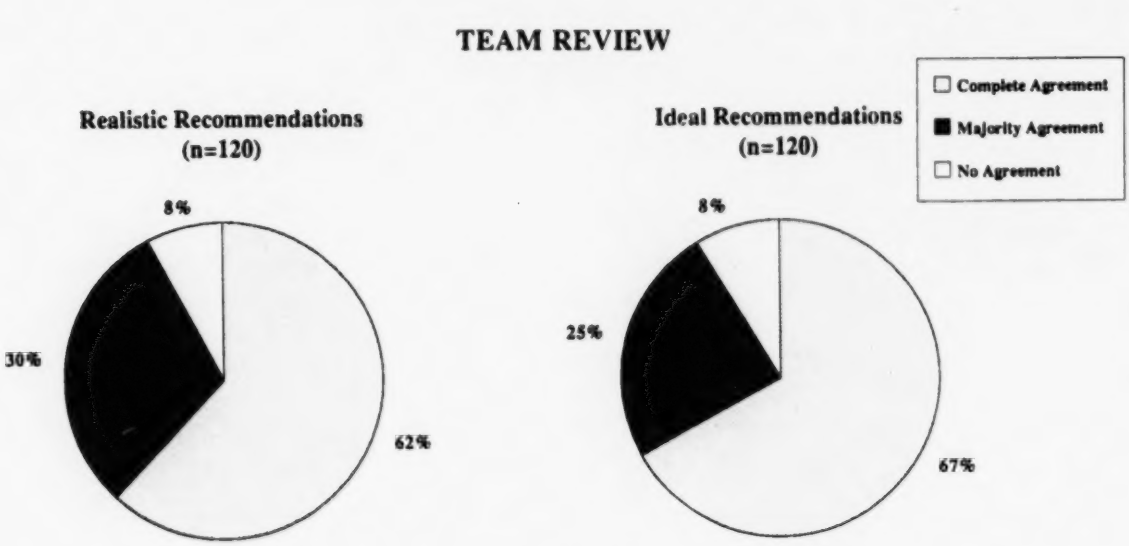
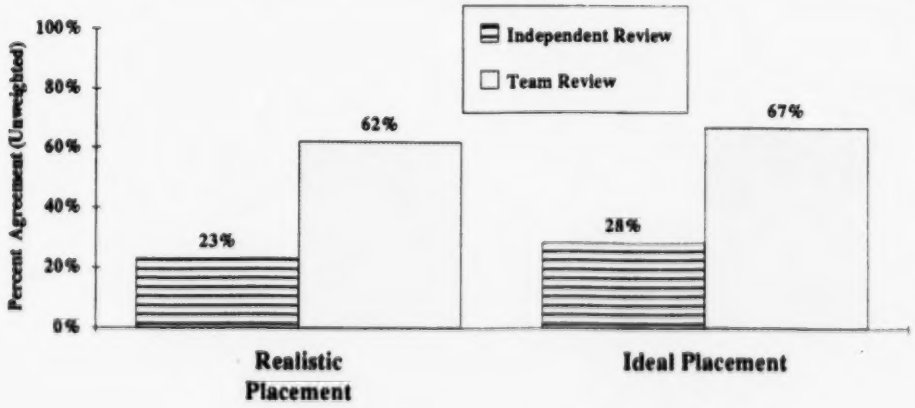
GRAPH C-1b: LEVEL OF PROFESSIONAL AGREEMENT (UNWEIGHTED) IN PLACEMENTS



Comparison of Agreement in the Independent and Team Reviews

Complete agreement increased more dramatically from Independent to Team Review when the unweighted numbers were analyzed. In the Independent Review, there was 23% (realistic) and 28% (ideal) complete agreement which increased substantially to 62% (realistic) and 67% (ideal) in the Team Review (Graph D-2). While the trend of increasing complete agreement is evident in weighted and unweighted numbers, the unweighted numbers give a greater value to this increase.

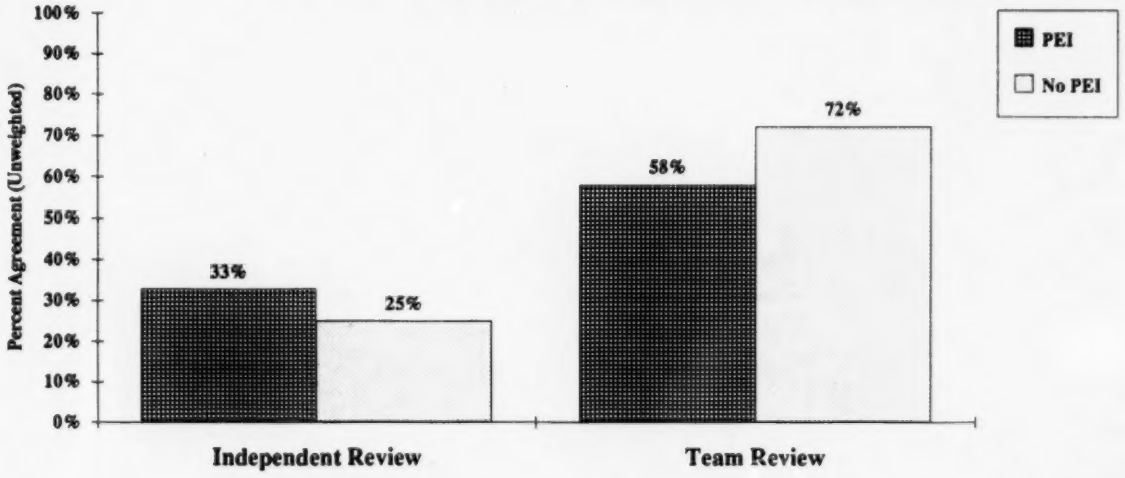
GRAPH C-2: COMPARISON OF RATES OF COMPLETE AGREEMENT AMONG PANELISTS IN PLACEMENT RECOMMENDATIONS



Agreement for Cases With and Without the Personal Experience Inventory (PEI)

When consensus is analyzed with regard to the PEI, the results must be weighted according to the probability of attaining a particular level of agreement. Graph C-3 shows the unweighted findings before weighting them according to the probabilities.

GRAPH C-3: LEVEL OF AGREEMENT FOR IDEAL PLACEMENT AMONG TEAM MEMBERS FOR CASES WITH AND WITHOUT THE PEI



APPENDIX D: DISTRIBUTION OF RECOMMENDATIONS FOR EACH COMMON CASE

Evaluation	Independent Realistic				Independent Ideal				Team Realistic				Team Ideal			
Modality	*IP*	*IOP*	*ROP*	*Other*	*IP*	*IOP*	*ROP*	*Other*	*IP*	*IOP*	*ROP*	*Other*	*IP*	*IOP*	*ROP*	*Other*
Case 1	2	7	4	2	5	5	3	2	2	8	5	0	6	4	5	0
Case 2	13	2	0	0	15	0	0	0	15	0	0	0	15	0	0	0
Case 3	0	0	4	11	0	0	5	10	0	0	5	10	0	0	5	10
Case 4	6	3	4	2	7	3	3	2	7	5	3	0	8	4	3	0
Case 5	8	5	2	0	9	6	0	0	10	5	0	0	11	4	0	0
Case 6	8	3	3	1	8	3	3	1	12	1	2	0	12	1	2	0
Case 7	3	5	6	1	6	4	4	1	5	2	8	0	6	2	7	0
Case 8	0	0	5	10	0	0	6	9	0	0	7	8	0	0	9	6
Case 9	9	3	2	1	11	2	1	1	12	3	0	0	13	1	0	1
Case 10	11	4	0	0	14	1	0	0	13	2	0	0	14	1	0	0
Case 11	6	4	3	2	7	7	0	1	7	6	1	1	9	4	1	1
Case 12	9	2	1	3	9	2	1	3	12	2	0	1	14	0	0	1
Totals	75	38	34	33	91	33	26	30	95	34	31	20	108	21	32	19

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APPENDIX E: SIGNIFICANCE TESTS USED IN REPORT

Figure	Analysis	Test Used	Values Obtained
Graph 3-3	From Independent to Team Review, Increase In Consensus (Weighted), General	Modified t test for the difference in proportions	Realistic, Z=5.75 (sig) Ideal, Z=5.00 (sig)
Graph 3-6	In Independent & Team Reviews, Level Of Consensus (Weighted), PEI v No PEI	Modified t test for the difference in proportions, and Chi Square test	Independent, Z=1.38 (ns)
Graph 3-8	In Independent Review, Correspondence Between Realistic & Ideal, East v West	Modified t test for the difference in proportions	Z=1.66 (ns)
Graph 3-10	For each of the Common Cases, the Level of Agreement was Tested for Significance	Modified t test for the difference in proportions	Values determined for each case, for Independent and Team Reviews, for both Ideal and Realistic placements
Graph 3-12	Percentage of Ideal Recommendations that correspond to Actual Placements in the Independent Review was higher for ROP than IP and IOP	Modified t test for the difference in proportions	IP v IOP, Z=1.46 (ns) IP v ROP, Z=6.65 (sig) IOP v ROP, Z=6.50 (sig)
Graph 3-13	Percentage of Realistic Recommendations that correspond to Actual Placements in the Independent Review was higher for ROP than IP and IOP	Modified t test for the difference in proportions	IP v IOP, Z=0.99 (ns) IP v ROP, Z=6.15 (sig) IOP v ROP, Z=6.06 (sig)
Graph 3-15	Percentage of cases for which Independent ideal recommendation and actual placements were the same, (higher for PEI cases)	Modified t test for the difference in proportions	Z=2.24 (sig)
Table 3-2	From Realistic to Ideal Placement, Increase In Mean Duration, By Modality	Standard t test	IP, t=8.50 (sig) IOP, t=1.93 (sig-1 tailed test) ROP, t=0.70 (ns)
Graph 3-16 and 3-17	Factors, Drug History Cited More Frequently for IP than IOP and ROP	Modified t test for the difference in proportions	Realistic: IP v ROP, Z=2.60 (sig) IOP v ROP, Z=1.43 (ns) IP v IOP, Z=0.96 (ns) Ideal: IP v ROP, Z=2.64 (sig) IOP v ROP, Z=1.78 (ns) IP v IOP, Z=0.63 (ns)
Graph 3-21	The presence of the PEI has an effect on the frequency "Family History", "Social Background", and "Drug History" were cited	Chi Squared Test	Family History, Chi Sq.=7.62 (sig) Social Backgd, Chi Sq.=2.66 (ns) Drug History, Chi Sq.=0.44 (ns)